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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10319

10371 CERTIFICATE OF DEATH

Reg. Dist. No. 9

Item 7. Film G190 12-7-55 et

| | | | | | | | |
|---|-------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY OR TOWN <u>Route 1, Frostburg</u> | | LENGTH OF STAY (In this place) <u>Lifetime</u> | | TOWN <u>Route 1, Frostburg</u> | | STREET ADDRESS (If rural give location) <u>None</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> | | | | STREET ADDRESS <u>None</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (First) <u>John</u> (Middle) <u>T.</u> (Last) <u>Albright</u> | | | | <u>Nov 23</u> <u>1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| <u>Male</u> | <u>White</u> | <u>Widower</u> | <u>August 1, 1872</u> | <u>83</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. rubber worker Springfield</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly-</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Jacob Albright</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Hannah Beal</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mrs. Vernon Loar, Rt. 1, Frostburg,</u> | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| <u>450.0</u> IMMEDIATE CAUSE (A) <u>Arterio sclerosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Serum</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | | 21e. INJURY OCCURRED White et work Not white et work | | 21f. HOW DID INJURY OCCUR? | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Sept 1, 1955</u>, to <u>Nov 23, 1955</u>, that I last saw the deceased alive on <u>Nov 18, 1955</u>, and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>W. Mc Lane</u> | | | | DATE SIGNED <u>Nov 23/1955</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | 24. REC'D BY REGISTRAR <u>Nov. 25, 55</u> | | | |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst</u> | | | | ADDRESS <u>Frostburg Md</u> | | | |
| 26. REGISTRAR'S SIGNATURE <u>Mr. Nancy N. Roe</u> | | | | 27. ADDRESS <u>Frostburg, Md.</u> | | | |
| DATE <u>11-25-55</u> | | | | | | | |

CERTIFICATE OF DEATH

1. Name of Deceased: **Allegany**

2. Date of Death: **Allegany**

3. Place of Birth: **Allegany**

4. Date of Birth: **Allegany**

5. Cause of Death: **Allegany**

6. Place of Death: **Allegany**

7. Name of Physician: **Allegany**

8. Name of Coroner: **Allegany**

9. Name of Registrar: **Allegany**

10. Name of Burial Place: **Allegany**

11. Name of Burial Place: **Allegany**

12. Name of Burial Place: **Allegany**

13. Name of Burial Place: **Allegany**

14. Name of Burial Place: **Allegany**

15. Name of Burial Place: **Allegany**

16. Name of Burial Place: **Allegany**

17. Name of Burial Place: **Allegany**

BUREAU V. 3

NOV 30 1955

RECEIVED

18. Name of Burial Place: **Allegany**

19. Name of Burial Place: **Allegany**

20. Name of Burial Place: **Allegany**

21. Name of Burial Place: **Allegany**

22. Name of Burial Place: **Allegany**

23. Name of Burial Place: **Allegany**

24. Name of Burial Place: **Allegany**

25. Name of Burial Place: **Allegany**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10320

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 7

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>W. Va.</u> | COUNTY <u>Mineral</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>R.F.D. #1 Ridgely</u> | <u>85x-3</u> |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Memorial Hospital</u> | | STREET ADDRESS (If rural, give location) <u>Old Furnace Road</u> | <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED: (Type or Print) | | 4. DATE OF DEATH | |
| (First) <u>Elsie</u> | (Middle) <u>Marie</u> | (Last) <u>Baldwin</u> | (Month) <u>Nov.</u> (Day) <u>4</u> (Year) <u>19 55</u> |
| 5. SEX: <u>female</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>single</u> | 8. DATE OF BIRTH: <u>Oct. 13-1955</u> |
| 9. AGE last birthday: <u>0</u> yrs. | | IF UNDER 1 YEAR Months <u>0</u> Days <u>22</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): <u>Cumberland, Md.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME: | | 14. MOTHER'S MAIDEN NAME: <u>Mary Ellen Baldwin</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: <u></u> | |
| 17. INFORMANT & ADDRESS: <u>R.F.D. #1-Ridgely, W. Va. (Grandmother) Mrs. Edna Baldwin</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | INTERVAL BETWEEN ONSET AND DEATH |
| 764.0 Immediate cause (a) <u>Malnutrition</u> DUE TO | | | <u>3 weeks</u> |
| Antecedent cause(s) (b) <u>Dehydration</u> DUE TO | | | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Gastro-enteritis.</u> | | | <u>3 weeks</u> |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION: <u>0</u> | | 19b. MAJOR FINDING OF OPERATION: | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) INJURY | 21c. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> | | | |
| SIGNATURE <u>H.V. Deming M.D. H.V. Deming M.D.</u> | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Nov. 4-1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | DATE THEREOF <u>11-6-55</u> | NAME OF CEMETERY OR CREMATORY <u>Abe Cemetery</u> | LOCATION (City, town, or county) (State) <u>Near Wiley Ford, W. Va.</u> |
| DATE RECD BY LOCAL REG. <u>Nov. 7, 1955</u> | REGISTRAR'S SIGNATURE <u>Walter R. Dranty M.D.</u> | 24. FUNERAL DIRECTOR <u>James F. Scarpelli Cumberland, Md.</u> | |
| <u>2005/17/445</u> | | | |

100-41801

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

BUREAU V. S.

NOV 9 1955

RECEIVED

Within corporate limits

10316

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10318

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

I. PLACE OF DEATH:

COUNTY

Allegheny

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN Cumberland

LENGTH OF STAY
(in this place)

49 days

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Pa.

COUNTY Somerset

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN

Myersdale

75X-3

STREET
ADDRESS

307 W. Garrett St.

3. NAME OF
DECEASED:
(Type or Print)

(First)

Anna

(Middle)

B.

(Last)

Barron

4. DATE
OF
DEATH

(Month)

Nov.

(Day)

5

(Year)

19

55

5. SEX:

female

6. COLOR OR
RACE:

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) married

8. DATE OF BIRTH:

April 7-1890

9. AGE last birthday:

65

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):

Housewife

10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Stoney Creek, Pa.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME:

Simon Baltzer

14. MOTHER'S MAIDEN NAME:

Etta Woy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

no

16. SOCIAL SECURITY No.:

none

17. INFORMANT & ADDRESS:

Memorial Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

203X

Immediate cause

(a) Multiple Myeloma

DUE TO

Antecedent cause(s)

(b) Diseases or conditions, if any,
giving rise to the above cause DUE TO
stating underlying cause last (c)INTERVAL BETWEEN
ONSET AND DEATH

6 months

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.Pathological Fractures 6-21/55 right femur
Sept-17-right humerus Oct-25-left forearm.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☒
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.)
INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY June 21/55 A. M.21e. INJURY OCCURRED
While at work ☐ Not while at work ☒21f. HOW DID INJURY OCCUR? Walking in kitchen
at home, fell, fractured right femur.22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and
find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H. V. Deming M.D.

H. V. Deming M.D.

M. D.

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.DATE SIGNED
Nov. 5-195523. BURIAL, CREMATION,
REMOVAL (Specify):

Cremation

DATE THEREOF

Nov 8, 1955

NAME OF CEMETERY OR CREMATORY

Stoney Creek Cemetery

LOCATION (City, town, or county)

Pittsburgh, Allegheny Co

(State)

DATE REC'D BY LOCAL
REG.

Nov 7, 1955

REGISTRAR'S SIGNATURE

H. V. Deming M.D.

24. FUNERAL DIRECTOR

Hauger Funeral Director Myersdale, Pa.

ADDRESS

Removal by James F. Scarpelli Cumberland Md

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 9 1955

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10372 CERTIFICATE OF DEATH

10321

40820

Reg. Dist. No. 8

| | | | | | | | |
|---|-------------------------|---|-------------------------|---|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>MD.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Midland</u> | | | | TOWN <u>Midland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Annie Virginia Berry</u> | | | | <u>Nov, 27 19 55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Widowed</u> | <u>May 22nd, 1876</u> | <u>79</u> | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housework</u> | | <u>Own Home</u> | | <u>Orleans, W.VA</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Thomas Emmart</u> | | | | <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>None</u> | | <u>Mr. Raymond Berry, Midland, MD.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION (SON) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 332X IMMEDIATE CAUSE (A) | | | | <u>Cerebral Thrombosis</u> | | <u>3 weeks</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | <u>Arteriosclerosis Generalized</u> | | <u>2 yrs.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| <u>0</u> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| <u>26 hr 95</u> | | <u>M.</u> | | <u>27 hr 55</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>July 19 55</u>, to <u>27 Nov, 55</u>, that I last saw the deceased alive on <u>26 Nov 55</u>, and that death occurred at <u>6:45 AM</u>, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| <u>George Richards</u> M.D. | | | | <u>Lonaconing, Md</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Nov, 29, 1955</u> | | <u>Memorial Park</u> | | <u>Frostburg, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>11/30/55</u> | | <u>Jeanette M. Royal</u> | | <u>GEORGE EICHHORN, Lonaconing, MD.</u> | | | |

CERTIFICATE OF DEATH

1955

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX OF DECEASED

8. AGE OF DECEASED

9. OCCUPATION OF DECEASED

10. MARITAL STATUS OF DECEASED

11. EDUCATION OF DECEASED

12. RACE OF DECEASED

13. COLOR OF DECEASED

14. RELIGION OF DECEASED

15. BIRTH DATE OF DECEASED

16. BIRTH PLACE OF DECEASED

17. BIRTH TIME OF DECEASED

18. BIRTH WEIGHT OF DECEASED

19. BIRTH LENGTH OF DECEASED

20. BIRTH HEAD CIRCUMFERENCE OF DECEASED

21. BIRTH SKIN COLOR OF DECEASED

22. BIRTH HAIR COLOR OF DECEASED

23. BIRTH EYE COLOR OF DECEASED

24. BIRTH NOSE COLOR OF DECEASED

25. BIRTH MOUTH COLOR OF DECEASED

26. BIRTH TEETH COLOR OF DECEASED

27. BIRTH FINGER COLOR OF DECEASED

28. BIRTH TOE COLOR OF DECEASED

29. BIRTH HEEL COLOR OF DECEASED

30. BIRTH PALM COLOR OF DECEASED

31. BIRTH SOLE COLOR OF DECEASED

32. BIRTH NAIL COLOR OF DECEASED

33. BIRTH SKIN TONE OF DECEASED

34. BIRTH SKIN TYPE OF DECEASED

35. BIRTH SKIN CONDITION OF DECEASED

36. BIRTH SKIN TEMPERATURE OF DECEASED

37. BIRTH SKIN PULSE OF DECEASED

38. BIRTH SKIN RESPIRATION OF DECEASED

39. BIRTH SKIN SWEAT OF DECEASED

40. BIRTH SKIN SECRETION OF DECEASED

41. BIRTH SKIN EXCRETION OF DECEASED

42. BIRTH SKIN ABSORPTION OF DECEASED

43. BIRTH SKIN PERMEABILITY OF DECEASED

44. BIRTH SKIN ELASTICITY OF DECEASED

45. BIRTH SKIN FLEXIBILITY OF DECEASED

46. BIRTH SKIN ADHESION OF DECEASED

47. BIRTH SKIN COHESION OF DECEASED

48. BIRTH SKIN TENSILE STRENGTH OF DECEASED

49. BIRTH SKIN COMPRESSIVE STRENGTH OF DECEASED

50. BIRTH SKIN TORSIONAL STRENGTH OF DECEASED

51. BIRTH SKIN IMPACT STRENGTH OF DECEASED

52. BIRTH SKIN VIBRATION STRENGTH OF DECEASED

53. BIRTH SKIN ACCELERATION STRENGTH OF DECEASED

54. BIRTH SKIN DECELERATION STRENGTH OF DECEASED

55. BIRTH SKIN RESONANCE STRENGTH OF DECEASED

56. BIRTH SKIN DAMPING STRENGTH OF DECEASED

57. BIRTH SKIN Hysteresis STRENGTH OF DECEASED

58. BIRTH SKIN Creep STRENGTH OF DECEASED

59. BIRTH SKIN Relaxation STRENGTH OF DECEASED

60. BIRTH SKIN Fatigue STRENGTH OF DECEASED

61. BIRTH SKIN Fracture STRENGTH OF DECEASED

62. BIRTH SKIN Yield STRENGTH OF DECEASED

63. BIRTH SKIN Ultimate STRENGTH OF DECEASED

64. BIRTH SKIN Modulus STRENGTH OF DECEASED

65. BIRTH SKIN Poisson's RATIO STRENGTH OF DECEASED

66. BIRTH SKIN Coefficient of Thermal Expansion STRENGTH OF DECEASED

67. BIRTH SKIN Coefficient of Thermal Contraction STRENGTH OF DECEASED

68. BIRTH SKIN Coefficient of Thermal Conductivity STRENGTH OF DECEASED

69. BIRTH SKIN Coefficient of Thermal Resistance STRENGTH OF DECEASED

70. BIRTH SKIN Coefficient of Thermal Capacity STRENGTH OF DECEASED

71. BIRTH SKIN Coefficient of Thermal Inertia STRENGTH OF DECEASED

72. BIRTH SKIN Coefficient of Thermal Diffusivity STRENGTH OF DECEASED

73. BIRTH SKIN Coefficient of Thermal Conductivity STRENGTH OF DECEASED

74. BIRTH SKIN Coefficient of Thermal Resistance STRENGTH OF DECEASED

75. BIRTH SKIN Coefficient of Thermal Capacity STRENGTH OF DECEASED

76. BIRTH SKIN Coefficient of Thermal Inertia STRENGTH OF DECEASED

77. BIRTH SKIN Coefficient of Thermal Diffusivity STRENGTH OF DECEASED

78. BIRTH SKIN Coefficient of Thermal Conductivity STRENGTH OF DECEASED

79. BIRTH SKIN Coefficient of Thermal Resistance STRENGTH OF DECEASED

80. BIRTH SKIN Coefficient of Thermal Capacity STRENGTH OF DECEASED

81. BIRTH SKIN Coefficient of Thermal Inertia STRENGTH OF DECEASED

82. BIRTH SKIN Coefficient of Thermal Diffusivity STRENGTH OF DECEASED

83. BIRTH SKIN Coefficient of Thermal Conductivity STRENGTH OF DECEASED

84. BIRTH SKIN Coefficient of Thermal Resistance STRENGTH OF DECEASED

85. BIRTH SKIN Coefficient of Thermal Capacity STRENGTH OF DECEASED

86. BIRTH SKIN Coefficient of Thermal Inertia STRENGTH OF DECEASED

87. BIRTH SKIN Coefficient of Thermal Diffusivity STRENGTH OF DECEASED

88. BIRTH SKIN Coefficient of Thermal Conductivity STRENGTH OF DECEASED

89. BIRTH SKIN Coefficient of Thermal Resistance STRENGTH OF DECEASED

90. BIRTH SKIN Coefficient of Thermal Capacity STRENGTH OF DECEASED

91. BIRTH SKIN Coefficient of Thermal Inertia STRENGTH OF DECEASED

92. BIRTH SKIN Coefficient of Thermal Diffusivity STRENGTH OF DECEASED

93. BIRTH SKIN Coefficient of Thermal Conductivity STRENGTH OF DECEASED

94. BIRTH SKIN Coefficient of Thermal Resistance STRENGTH OF DECEASED

95. BIRTH SKIN Coefficient of Thermal Capacity STRENGTH OF DECEASED

96. BIRTH SKIN Coefficient of Thermal Inertia STRENGTH OF DECEASED

97. BIRTH SKIN Coefficient of Thermal Diffusivity STRENGTH OF DECEASED

98. BIRTH SKIN Coefficient of Thermal Conductivity STRENGTH OF DECEASED

99. BIRTH SKIN Coefficient of Thermal Resistance STRENGTH OF DECEASED

100. BIRTH SKIN Coefficient of Thermal Capacity STRENGTH OF DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

| | | | |
|---|-------------------|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY | Allegany | STATE | W.Va. COUNTY Hampshire |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | CUMBERLAND | CITY (If outside corporate limits write RURAL and give nearest town) | Romney 85 x .3 |
| TOWN | | TOWN | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | Memorial Hospital | STREET ADDRESS | (If rural, give location) |
| 3. NAME OF DECEASED: | (First) John | (Middle) L. | (Last) Blackburn |
| (Type or Print) | | | |
| 4. DATE OF DEATH | Nov. 27 | (Month) | (Day) 19 55 |
| 5. SEX: | male | 6. COLOR OR RACE: | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | married | 8. DATE OF BIRTH: | March 12-1887 |
| 9. AGE last birthday: | 68 | IF UNDER 1 YEAR | Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, or if retired): | Farmer | 10b. KIND OF BUSINESS OR INDUSTRY: | Own farm |
| 11. BIRTHPLACE (State or foreign country): | Antioch, W.Va. | 12. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 13. FATHER'S NAME: | George Blackburn | 14. MOTHER'S MAIDEN NAME: | Mary Parker |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | no | 16. SOCIAL SECURITY No.: | |
| (If Yes, give war or dates of service) | | 17. INFORMANT & ADDRESS: | (son) Charles Blackburn, Romney, W.Va. |

| | | |
|--|--|--|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | |
| 241X Immediate cause (a) Myocardial failure | | gradual |
| DUE TO | | |
| Antecedent cause(s) (b) Myocarditis | | ? |
| Diseases or conditions, if any, giving rise to the above cause DUE TO | | about |
| stating underlying cause last (c) Bronchial asthma | | 3 years. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |
| 19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) (County) (State) |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | |
| SIGNATURE | | |
| H.V. Deming M.D. H.V. Deming M.D. M.D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. DATE SIGNED Nov. 28-1955 | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY |
| Burial | Nov. 30, 1955 | Scherr Cemetery |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
| Nov. 29, 1955 | Winters R. Frantz, M.D. | Melba Combs, Romney, West Virginia |
| Knight - Combs | | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 30 1955

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1032V

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|---------------------------|--|---------------------------------------|---|-----------------------------|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY OR TOWN <u>Cumberland</u> | | LENGTH OF STAY (in this place) <u>1 mo. 16 days</u> | | CITY OR TOWN <u>Borden Mines, Frostburg</u> | | CITY OR TOWN <u>Borden Mines, Frostburg</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u> | | | | STREET ADDRESS (If rural give location) <u></u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>Blank</u> (Middle) <u></u> (Last) | | | | 4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>23</u> (Year) <u>1955</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u> | 8. DATE OF BIRTH <u>Feb. 17, 1878</u> | 9. AGE last birthday <u>77</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Borden Mines, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Benjamin Ort</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Brode</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mrs. Frank Schriver, Borden Mine, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 592X IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u> | | | | <u>?</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Nephritis</u> | | | | <u>?</u> | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis</u> | | | | <u>2-3 mos</u> | | | |
| 19a. DATE OF OPERATION <u>0</u> | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Oct. 7, 1955</u>, to <u>Nov. 23, 1955</u>, that I last saw the deceased alive on <u>Nov. 23, 1955</u>, and that death occurred at <u>5:45 P.</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>James B. Fleau</u> M.D. | | | | DATE SIGNED <u>11-25-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>11-26-55</u> | | NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u> | | LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u> | |
| 24. REC'D BY REGISTRAR <u>Nov. 26, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Kautz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Harper Funeral Home</u> ADDRESS <u>Frostburg, Md.</u> | | | |

CERTIFICATE OF DEATH

Reg. No. 115

1. Name of deceased (Print or write)

2. Date of death

3. Sex of deceased

4. Age of deceased

5. Race of deceased

6. Place of birth

7. Usual residence

8. Cause of death

9. Duration of illness

10. Place of death

11. Name of physician

12. Name of attending physician

13. Name of hospital

14. Name of funeral home

15. Name of undertaker

16. Name of cemetery

17. Name of church

18. Name of minister

19. Name of sexton

20. Name of sexton

21. Name of sexton

22. Name of sexton

23. Name of sexton

24. Name of sexton

25. Name of sexton

26. Name of sexton

27. Name of sexton

28. Name of sexton

29. Name of sexton

30. Name of sexton

31. Name of sexton

32. Name of sexton

33. Name of sexton

34. Name of sexton

35. Name of sexton

36. Name of sexton

37. Name of sexton

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55. Name of sexton

56. Name of sexton

57. Name of sexton

58. Name of sexton

59. Name of sexton

60. Name of sexton

BUREAU V. S.

NOV 20 1955

RECEIVED

SHOULD BE

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10322

Reg. Dist. No. 9

| | | | | | | | |
|---|---|---|--|--|---------------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Allegany | | STATE Maryland | | COUNTY Allegany | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg | | LENGTH OF STAY (in this place) 4-5 hrs. | | CITY (If outside corporate limits, write RURAL and give nearest town) Eckhart | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 6 Miners Hospital | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (First) JOHN (Middle) A. (Last) BOYLE | | | | 4. DATE OF DEATH (Month) Nov. (Day) 29 (Year) 19 55 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single | 8. DATE OF BIRTH 2-2-1900 | 9. AGE last birthday 55 yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender | | 10b. KIND OF BUSINESS OR INDUSTRY Cafe | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Dennis A. Boyle | | | | 14. MOTHER'S MAIDEN NAME Bernadette Moore | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or deces of service) | | 16. SOCIAL SECURITY NO. 220-07-6678 | | 17. INFORMANT & ADDRESS Mary Boyle, Eckhart, Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH- | | | | | | 18. MEDICAL CERTIFICATION | |
| 420.1 IMMEDIATE CAUSE (A) Coronary occlusion | | | | | | INTERVAL BETWEEN ONSET AND DEATH 11 hrs. | |
| ANTECEDENT CAUSE(S) DUE TO (B) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION 0 | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 11-29, 19 55, to 11-29, 19 55, that I last saw the deceased alive on 11-29, 19 55, and that death occurred at 4:20 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE H.C. Diehl, M.D. | | | | ADDRESS (Street, city, town, state) Frostburg, Md. | | DATE SIGNED 11/30/55 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 12-2-55 | | NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery | | LOCATION (City, town, or county) (State) Frostburg, Md. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE J. R. Durst | | 25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md. | | | |
| DATE 12-1-55 | | | | | | | |

RECEIVED

DEC 5 1956

BUREAU V. S.

| | | | |
|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. DATE OF DEATH | |
| 3. PLACE OF DEATH | | 4. TIME OF DEATH | |
| 5. SEX | | 6. AGE | |
| 7. RACE | | 8. OCCUPATION | |
| 9. MARITAL STATUS | | 10. EDUCATION | |
| 11. RELIGION | | 12. CAUSE OF DEATH | |
| 13. MANNER OF DEATH | | 14. SIGNATURE OF PHYSICIAN | |
| 15. SIGNATURE OF WITNESSES | | 16. SIGNATURE OF DECEASED | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

10319

10323

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

| | | | | | |
|---|---|--|---|---|------------------------------|
| 1. PLACE OF DEATH: | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | |
| COUNTY | Allegany | | MARYLAND | STATE | Md. COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | Cumberland | | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town) | Cresaptown |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | Dead on arrival at the Sacred Heart Hospital. | | STREET ADDRESS | (If rural, give location) | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | 4. DATE OF DEATH (Month) (Day) (Year) | | |
| Patrick Bridges | | | Nov. 27 19 55 | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| male | white | Widower | Sept. 21-1876 | 79 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
| Miner & Sawmill worker. | | | | Cumberland Valley, Pa. | U.S.A. |
| 13. FATHER'S NAME: | | | 14. MOTHER'S MAIDEN NAME: | | |
| Benton Bridges | | | Anna Miller | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | 16. SOCIAL SECURITY No.: | | |
| no | | | 215-18-8119 | | |
| 17. INFORMANT & ADDRESS: | | | Md. (daughter) Harriett Allison, Cumberland | | |

| | | | | | |
|--|--|--|--|--------------------------------------|--|
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | sudden | |
| 420.1 Immediate cause (a) DUE TO Coronary occlusion | | | | | |
| Antecedent cause(s) (b) DUE TO Coronary sclerosis | | | | ? | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDING OF OPERATION: | |
| | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| H.V. Deming M.D. | | M. D. | | Nov. 27-1955 | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | |
| Burial | | Nov. 29, 1955 | | St. Patrick's Cemetery | |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR ADDRESS | |
| Nov. 28, 1955 | | Walter R. Hantz, M.D. | | William A. Light, Cumberland | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 29 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10324

10373 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allerany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allerany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR | |
| TOWN <u>Flintstone</u> | | 50 yrs | | TOWN <u>Flintstone</u> | | OR | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (First) (Middle) (Last) | | | | Nov. 24, 1955 19 | | | |
| WILLIAM HENRY BROWNING | | | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH | |
| Male | | White | | Married | | Aug. 29, 1869 | |
| 9. AGE last birthday | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 86 yrs. | | Months Days | | Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Ret. Farmer | | | | General Farming | | Artemas, Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| George Browning | | | | Massay Smith | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | |
| No | | | | None | | Mrs. Cornelia Browning, Flintstone Md. | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 450.0 IMMEDIATE CAUSE (A) | | | | | | Arteriosclerosis | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | (B) | |
| STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | Benign hypertrophy prostate | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from 9-14-1955, to 11-24-1955, that I last saw the deceased alive on 11-25-1955, and that death occurred at 6 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| Howard L. Tolson M.D. | | | | 11-26-55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | |
| Burial | | | | Nov. 26, 1955 | | Hillcrest Burial Park | |
| 24. REC'D BY REGISTRAR | | | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | |
| Nov. 26, 1955 | | | | Hina L. Bender. | | John J. Hafer, Cumberland, Maryland | |

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10325

Within corporate limits. 10320

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|-------------------------------|--|---------------------------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Cumberland</u> | | | | TOWN <u>Cumberland</u> | | 02 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>234 Columbia Street</u> | | | | STREET ADDRESS (If rural give location) <u>234 Columbia Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Ella</u> (First) <u>Burke</u> (Middle) (Last) | | | | 4. DATE OF DEATH <u>November 13</u> 19 <u>55</u> (Month) (Day) (Year) | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Feb. 10, 1874</u> | 9. AGE last birthday <u>81</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Kingsville, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Matthew Davis</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anne Brady</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>234 Columbia Street</u> <u>Gertrude Burke, Cumberland, Maryland</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>443x Hypertensive Arterio-</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>sclerotic Cardiovascular</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>disease.</u> | | | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Adams Stokes Syndrome</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>10-15-1955</u> to <u>11-13-1955</u> , that I last saw the deceased alive on <u>11-7-1955</u> , and that death occurred at <u>9:10 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>W. H. Williams</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Cumberland Md.</u> | | DATE SIGNED <u>11-15-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Nov. 16, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Patricks' Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Winter R. Dranty M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer,</u> | | ADDRESS <u>Cumberland, Maryland</u> | |
| DATE <u>Nov 16, 1955</u> | | | | | | | |

1955

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

LEGAL RESIDENCE (NAME OF DECEASED)

MARITAL STATUS

DATE OF BIRTH

SEX

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

BUREAU V. 1

NOV 17 1955

RECEIVED

UNRECORDED

W1: **ath:** this this

10321 CERTIFICATE OF DEATH

10328

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY ALLEGANY | | STATE MARYLAND COUNTY ALLEGANY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES., | | STREET ADDRESS (If rural give location) 308 N. MECHANIC ST | |
| 3. NAME OF DECEASED (First) (Middle) (Last) ESTHER ESTELLA BURKETT | | 4. DATE OF DEATH (Month) (Day) (Year) NOV. 16 19 55 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH MARCH 10, 1881 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | 11. BIRTHPLACE (State or foreign country) Waynesburg, Va. |
| 13. FATHER'S NAME BENJAMIN PAYNE | | 14. MOTHER'S MAIDEN NAME SUSAN POTTS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO | | 17. INFORMANT & ADDRESS HOWARD BURKETT, CUMBERLAND, MD. | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) <i>Chronic Arterio Sclerotic Cardio Vascular Disease</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i> | |
| ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION 0 | | 19b. MAJOR FINDINGS OF OPERATION | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) Nov-16, 1955 | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov-16, 1955 | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 22. I hereby certify that I attended the deceased from Nov-16, 1955, to Nov-16, 1955, that I last saw the deceased alive on Nov-16, 1955, and that death occurred at 1:28 P.M. from the causes and on the date stated above. | | | |
| SIGNATURE <i>John A. Topper</i> | | DATE SIGNED <i>11/16/55</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md. | |
| 25. REC'D BY REGISTRAR Nov. 18, 1955 | | 26. REGISTRAR'S SIGNATURE <i>Walter L. Frantz, M.D.</i> | |

CERTIFICATE OF DEATH

| | | | |
|---------------------------------------|--|---------------------------------------|--|
| PLACE OF BIRTH ALLEGANY | | PLACE OF DEATH ALLEGANY | |
| SEX MALE | | SEX MALE | |
| RACE WHITE | | RACE WHITE | |
| DATE OF BIRTH 17 FEB 1888 | | DATE OF DEATH 17 FEB 1935 | |
| TIME OF DEATH 10:00 AM | | TIME OF DEATH 10:00 AM | |
| PLACE OF DEATH ALLEGANY | | PLACE OF DEATH ALLEGANY | |
| CAUSE OF DEATH CORONARY THROMBOSIS | | CAUSE OF DEATH CORONARY THROMBOSIS | |
| MANNER OF DEATH NATURAL | | MANNER OF DEATH NATURAL | |
| SIGNATURE OF DECEASED [Signature] | | SIGNATURE OF DECEASED [Signature] | |
| SIGNATURE OF WITNESS [Signature] | | SIGNATURE OF WITNESS [Signature] | |
| SIGNATURE OF PHYSICIAN [Signature] | | SIGNATURE OF PHYSICIAN [Signature] | |
| SIGNATURE OF CLERK [Signature] | | SIGNATURE OF CLERK [Signature] | |

BUREAU V. S.

NOV 21 1935

RECEIVED

THIS CERTIFICATE IS NOT VALID UNLESS IT IS SIGNED BY THE CLERK OF THE HEALTH DEPARTMENT OF THE STATE OF MARYLAND. IT IS THE DUTY OF THE CLERK TO SIGN THIS CERTIFICATE ONLY WHEN THE DECEASED IS A RESIDENT OF MARYLAND. IF THE DECEASED IS A RESIDENT OF ANOTHER STATE, THIS CERTIFICATE SHOULD BE SIGNED BY THE CLERK OF THE HEALTH DEPARTMENT OF THAT STATE. IF THE DECEASED IS A RESIDENT OF A FOREIGN COUNTRY, THIS CERTIFICATE SHOULD BE SIGNED BY THE CONSUL OF THE UNITED STATES IN THAT COUNTRY.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

FilmG189 11-16-55 et

10327

Outside City Limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|------------------|--|-----------------------------------|---|---|---|------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Route I Cumberland</u> | | <u>35 Yrs</u> | | TOWN <u>Route I Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. I</u> | | | | STREET ADDRESS (If rural give location) <u>Route I</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>James Henry Burkhart</u> | | | | <u>November 7 19 55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>Widowed</u> | <u>2/12/ 1876</u> | <u>79 yrs.</u> | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| <u>Carpenter</u> | | | | | <u>Penn.</u> | | <u>U.S.A.</u> |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Jacob J Burkhart</u> | | | | <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>213 24 7487</u> | | <u>Mrs Violet Loar Rt. I Cumberland</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>Chronic arteriosclerotic Heart Disease</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>10-7</u> , <u>19 55</u> , <u>to</u> <u>11-7</u> , <u>19 55</u> , <u>that I last saw the deceased alive on</u> <u>11-6</u> , <u>19 55</u> , <u>and that death occurred at</u> <u>4:30 A.M.</u> , <u>from the causes and on the date stated above.</u> SIGNATURE <u>John L. Topper</u> M.D. <u>Wynne R</u> DATE SIGNED <u>11/9/55</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>11/9/55</u> | | <u>Hillcrest Cemetery</u> | | <u>Cumberland Maryland</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>11-9-55</u> | | <u>Walter R Brantley</u> | | <u>Lois Stein, Inc.</u> | | <u>Cumberland, Md.</u> | |

SMITHSONIAN INSTITUTION

RECEIVED
NOV 14 1955
BUREAU V. 8

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH - WASHINGTON, D. C.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED <i>James A. Smith</i> | | 2. PLACE OF BIRTH <i>St. Louis, Mo.</i> | |
| 3. SEX <i>Male</i> | | 4. AGE <i>45</i> | |
| 5. OCCUPATION <i>Engineer</i> | | 6. CAUSE OF DEATH <i>Heart Disease</i> | |
| 7. DATE OF DEATH <i>Nov 10, 1955</i> | | 8. PLACE OF DEATH <i>Home</i> | |
| 9. SIGNATURE OF DECEASED <i>James A. Smith</i> | | 10. SIGNATURE OF WITNESS <i>John A. Smith</i> | |
| 11. SIGNATURE OF PHYSICIAN <i>Dr. J. A. Smith</i> | | 12. SIGNATURE OF REGISTRAR <i>John A. Smith</i> | |
| 13. SIGNATURE OF CLERK <i>John A. Smith</i> | | 14. SIGNATURE OF OFFICIAL <i>John A. Smith</i> | |
| 15. SIGNATURE OF DECEASED <i>James A. Smith</i> | | 16. SIGNATURE OF WITNESS <i>John A. Smith</i> | |
| 17. SIGNATURE OF PHYSICIAN <i>Dr. J. A. Smith</i> | | 18. SIGNATURE OF REGISTRAR <i>John A. Smith</i> | |
| 19. SIGNATURE OF CLERK <i>John A. Smith</i> | | 20. SIGNATURE OF OFFICIAL <i>John A. Smith</i> | |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10328

Reg. Dist. No. 4

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY Allegany | MARYLAND | STATE Maryland | COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland | LENGTH OF STAY (in this place) 9/19/55 | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary | STREET ADDRESS 328 Fayette Street | | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| William C. Burrell | | November 24, 1955 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH 12/5/1867 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - - | | 10b. KIND OF BUSINESS OR INDUSTRY Salesman | 9. AGE last birthday 87 yrs. |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME George Burrell | | 14. MOTHER'S MAIDEN NAME Sarah Shuman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | | 16. SOCIAL SECURITY NO. 215 16 4510 | |
| 17. INFORMANT & ADDRESS Allegany County Infirmary Records | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) 422-2 Pulmonary Hypostasis | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs | |
| ANTECEDENT CAUSE(S) DUE TO (B) Chronic Myocarditis | | ? | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Cerebral Arteriosclerosis | | ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Hepatitis | | | |
| 19a. DATE OF OPERATION 8 | | 19b. MAJOR FINDINGS OF OPERATION | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Sept 19, 1935 to Nov 21, 1955 , that I last saw the deceased alive on Nov 23, 1955 , and that death occurred at 5:40 A.M. from the causes and on the date stated above. | | | |
| SIGNATURE James E. McLean M.D. | | ADDRESS (Street, city, town, state) 49 Greene St. Keedysville, Md. | |
| DATE SIGNED 11-25-55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF Nov. 26, 1955 | |
| NAME OF CEMETERY OR CREMATORY Fairview Cemetery | | LOCATION (City, town, or county) (State) Keedysville, Md. | |
| 24. REC'D BY REGISTRAR Nov. 26, 1955 | | 25. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md. | |

1955 CERTIFICATE OF DEATH

Form No. 100

1. Name of deceased (Print or type)

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Manner of death

9. Signature of physician

10. Signature of coroner

11. Signature of registrar

12. Date of registration

13. Signature of registrar

14. Signature of registrar

15. Signature of registrar

16. Signature of registrar

17. Signature of registrar

18. Signature of registrar

19. Signature of registrar

20. Signature of registrar

21. Signature of registrar

22. Signature of registrar

23. Signature of registrar

BUREAU V. S.

NOV 20 1955

RECEIVED

NOV 21 1955

TO THE CLERK OF THE DISTRICT COURT OF BALTIMORE
FROM THE REGISTRAR OF DEATHS
BALTIMORE, MD

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10329

Within corporate limits

10323

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|-------------------------|---|-------------------------|---|------------------------|--|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Cumberland,</u> | | | | TOWN <u>Cumberland,</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>31 Prospect Square</u> | | | | STREET ADDRESS (If rural give location) <u>31 Prospect Square</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>HENRIETTA FRANCES COOK</u> | | | | <u>Nov. 4, 1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Widowed</u> | <u>Feb. 14, 1875</u> | <u>80</u> | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housewife</u> | | <u>Own home</u> | | <u>Cumberland, Maryland</u> | | <u>U. S.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Henry Gerdeman</u> | | | | <u>Elizabeth Schellhaus</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No.</u> | | <u>None</u> | | <u>Cumberland, Md.</u> <u>Mrs. Russell Ponton 31 Prospect Square</u> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>792X</u> IMMEDIATE CAUSE (A) <u>Uremia</u> | | | | | | <u>13 days</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| <u>None</u> | | <u>None</u> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Oct. 23, 1955</u>, to <u>Nov. 4, 1955</u>, that I last saw the deceased alive on <u>Nov. 3, 1955</u>, and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>C. E. Zimmerman</u> | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| | | | | <u>M.D. 105 S. Centre St.</u> | | <u>11-5-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>11/7/55</u> | | <u>Rose Hill Cemetery</u> | | <u>Cumberland, Maryland</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Nov. 7, 1955</u> | | <u>Walter R. Dranty M.D.</u> | | <u>Charles L. George</u> | | <u>Cumberland, Md.</u> | |

10000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

| | | | | | |
|-----------------------------|--|--------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. PLACE OF BIRTH | | 5. OCCUPATION | | 6. CAUSE OF DEATH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. SIGNATURE OF DECEASED | | 11. SIGNATURE OF WITNESS | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF CLERK | | 14. SIGNATURE OF JUDGE | | 15. SIGNATURE OF SHERIFF | |
| 16. SIGNATURE OF CORONER | | 17. SIGNATURE OF JURY | | 18. SIGNATURE OF COURT | |
| 19. SIGNATURE OF PROSECUTOR | | 20. SIGNATURE OF DEFENSE | | 21. SIGNATURE OF JUDGE | |
| 22. SIGNATURE OF CLERK | | 23. SIGNATURE OF JURY | | 24. SIGNATURE OF COURT | |
| 25. SIGNATURE OF PROSECUTOR | | 26. SIGNATURE OF DEFENSE | | 27. SIGNATURE OF JUDGE | |
| 28. SIGNATURE OF CLERK | | 29. SIGNATURE OF JURY | | 30. SIGNATURE OF COURT | |
| 31. SIGNATURE OF PROSECUTOR | | 32. SIGNATURE OF DEFENSE | | 33. SIGNATURE OF JUDGE | |
| 34. SIGNATURE OF CLERK | | 35. SIGNATURE OF JURY | | 36. SIGNATURE OF COURT | |
| 37. SIGNATURE OF PROSECUTOR | | 38. SIGNATURE OF DEFENSE | | 39. SIGNATURE OF JUDGE | |
| 40. SIGNATURE OF CLERK | | 41. SIGNATURE OF JURY | | 42. SIGNATURE OF COURT | |
| 43. SIGNATURE OF PROSECUTOR | | 44. SIGNATURE OF DEFENSE | | 45. SIGNATURE OF JUDGE | |
| 46. SIGNATURE OF CLERK | | 47. SIGNATURE OF JURY | | 48. SIGNATURE OF COURT | |
| 49. SIGNATURE OF PROSECUTOR | | 50. SIGNATURE OF DEFENSE | | 51. SIGNATURE OF JUDGE | |
| 52. SIGNATURE OF CLERK | | 53. SIGNATURE OF JURY | | 54. SIGNATURE OF COURT | |
| 55. SIGNATURE OF PROSECUTOR | | 56. SIGNATURE OF DEFENSE | | 57. SIGNATURE OF JUDGE | |
| 58. SIGNATURE OF CLERK | | 59. SIGNATURE OF JURY | | 60. SIGNATURE OF COURT | |
| 61. SIGNATURE OF PROSECUTOR | | 62. SIGNATURE OF DEFENSE | | 63. SIGNATURE OF JUDGE | |
| 64. SIGNATURE OF CLERK | | 65. SIGNATURE OF JURY | | 66. SIGNATURE OF COURT | |
| 67. SIGNATURE OF PROSECUTOR | | 68. SIGNATURE OF DEFENSE | | 69. SIGNATURE OF JUDGE | |
| 70. SIGNATURE OF CLERK | | 71. SIGNATURE OF JURY | | 72. SIGNATURE OF COURT | |
| 73. SIGNATURE OF PROSECUTOR | | 74. SIGNATURE OF DEFENSE | | 75. SIGNATURE OF JUDGE | |
| 76. SIGNATURE OF CLERK | | 77. SIGNATURE OF JURY | | 78. SIGNATURE OF COURT | |
| 79. SIGNATURE OF PROSECUTOR | | 80. SIGNATURE OF DEFENSE | | 81. SIGNATURE OF JUDGE | |
| 82. SIGNATURE OF CLERK | | 83. SIGNATURE OF JURY | | 84. SIGNATURE OF COURT | |
| 85. SIGNATURE OF PROSECUTOR | | 86. SIGNATURE OF DEFENSE | | 87. SIGNATURE OF JUDGE | |
| 88. SIGNATURE OF CLERK | | 89. SIGNATURE OF JURY | | 90. SIGNATURE OF COURT | |
| 91. SIGNATURE OF PROSECUTOR | | 92. SIGNATURE OF DEFENSE | | 93. SIGNATURE OF JUDGE | |
| 94. SIGNATURE OF CLERK | | 95. SIGNATURE OF JURY | | 96. SIGNATURE OF COURT | |
| 97. SIGNATURE OF PROSECUTOR | | 98. SIGNATURE OF DEFENSE | | 99. SIGNATURE OF JUDGE | |
| 100. SIGNATURE OF CLERK | | 101. SIGNATURE OF JURY | | 102. SIGNATURE OF COURT | |

BUREAU V. S.

RECEIVED

PHOTOGRAPH

10324 **CERTIFICATE OF DEATH**

DR. STEGMAIER

Reg. Dist. No. 4

| | | | | | | | |
|--|-------------------------|---|-------------------------|---|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | STATE MARYLAND | | COUNTY ALLEGANY | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 17 DAYS | | TOWN CUMBERLAND | | rural | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS | | (If rural give location) | |
| MEMORIAL HOSPITAL | | | | MEXICO FARMS | | R. D. 4 | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| JAMES CRITES | | | | NOV. 12 1955 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| MALE | WHITE | WIDOWED | 4/11/73 | 82 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| FARMING | | Own Farm | | WEST VIRGINIA | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| JACOB CRITES | | | | SARAH MONGOLD | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | | | MEMORIAL HOSPITAL - CUMBERLAND, MD. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 422.1 | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) | | | | | | 4 days | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST, DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| | | While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | |
| 22. I hereby certify that I attended the deceased from 3:00 PM, 1955, to 12:00 PM, 1955, that I last saw the deceased alive on 11:00 PM, 1955, and that death occurred at 12:15 AM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| James B. Stegmaier | | | | 1224 Centre | | 12:00 PM 55 | |
| M.D. | | | | Cumberland Md. | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | Nov. 14, 1955 | | Davis Memorial Cemetery | | Cumberland, Md. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| Nov. 14, 1955 | | Walter R. Frantz, M.D. | | Charles L. George | | Cumberland, Md. | |

1 Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

NOV 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10331

Reg. Dist.

No. 9

| | | | | | | | |
|---|--------------------------------|---|---------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | | |
| TOWN <u>Frostburg</u> | | <u>3 days</u> | | TOWN <u>(rural) Gilmore</u> X | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u> | | | | STREET ADDRESS (If rural, give location) <u>A.S.D. #1 Frostburg, Md.</u> | | | |
| 3. NAME OF DECEASED: (First) <u>Mary</u> | | (Middle) <u>Melva</u> | | (Last) <u>Cuthbertson</u> | | 4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>14</u> (Year) <u>1955</u> | |
| 5. SEX: <u>female</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u> | 8. DATE OF BIRTH: <u>July 26-1946</u> | 9. AGE last birthday: <u>9</u> yrs. | IF UNDER 1 YEAR: Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): <u>Frostburg, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Melvin Cuthbertson</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Bernadine Kenney</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>#no</u> | | 16. SOCIAL SECURITY No.: <u>none</u> | | 17. INFORMANT & ADDRESS: <u>Miners Hospital records.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Immediate cause <u>812X</u> (a) <u>Subdural hemorrhage, (diffuse, slight)</u> DUE TO | | | | | | 3 days | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) <u>Contusion of brain (right)</u> DUE TO <u>Intra-abdominal hemorrhage (slight)</u> (c) <u>Ruptured spleen.</u> | | | | | | 3 days | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: <u>Nov. 12/55</u> | | | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>Injury Highway 36</u> | | 21c. (City or town) (County) (State) <u>Gilmore Allegany Md.</u> | | | |
| 21d. TIME (Month) (Day) (Year) <u>Nov. 12/55</u> (Hour) <u>P. M.</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Hit by the left front fender of a car on route #36</u> | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>H.V. Deming M.D.</u> | | M. D. <u>H.V. Deming M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Nov. 14-1955</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF <u>Nov. 17, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Michael Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Frostburg, MD.</u> | |
| DATE REC'D BY LOCAL REG. <u>11-16-55</u> | | REGISTRAR'S SIGNATURE <u>Mrs. Nancy A. Roe</u> | | 24. FUNERAL DIRECTOR <u>George Eichhorn</u> | | ADDRESS <u>Lonaconing, MD</u> | |

1258

BUREAU V. S.

NOV 18 1955

RECEIVED

Outside of
City Limits

10375

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10332

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | OR | |
| TOWN <u>Rural) Cumberland</u> | | | | TOWN <u>Rural) Cumberland</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. #3 Bowmans Addition</u> | | | | STREET ADDRESS (If rural, give location) <u>R.F.D. #3 Bowmans Addition</u> | | | |
| 3. NAME OF DECEASED: (First) <u>Henry</u> | | (Middle) <u>Walter</u> | | (Last) <u>Friend</u> | | 4. DATE OF DEATH <u>Nov. 9 19 55</u> | |
| 5. SEX: <u>male</u> | | 6. COLOR OR RACE: <u>white</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u> | | 8. DATE OF BIRTH: <u>Nov. 4 1873</u> | |
| 9. AGE last birthday: <u>82</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired track foreman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>B&O R.Ry.</u> | | 11. BIRTHPLACE (State or foreign country): <u>Swanton, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME: <u>John B. Friend</u> | | | |
| 14. MOTHER'S MAIDEN NAME: <u>Harriet Comp</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | | |
| 16. SOCIAL SECURITY No.: <u>4</u> | | | | 17. INFORMANT & ADDRESS: <u>R.F.D. #3 Bowmans Add (son) Albert Friend, (rural) Cumberland Md</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| 442 X Immediate cause (a) <u>Myocardial Failure</u> | | | | | | Gradual | |
| Antecedent cause(s) (b) <u>Cardio-vascular-renal disease.</u> | | | | | | ? | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | | | | | 19b. MAJOR FINDING OF OPERATION: | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) | | (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE | | NAME OF GEMETERY OR CREMATORY | | LOCATION (City, town, or county) | | DATE SIGNED | |
| <u>H.V. Deming M.D.</u> | | <u>United Brethren Cemetery</u> | | <u>Swanton, Maryland</u> | | <u>Nov. 9-1955</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE THEREOF | | LOCATION (City, town, or county) | | (State) | |
| <u>Burial</u> | | <u>Nov. 12, 1955</u> | | <u>Swanton, Maryland</u> | | | |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>Nov. 11, 1955</u> | | <u>Walter R. Frantz, M.D.</u> | | <u>Louis Stern, Inc.</u> | | <u>Cumberland, Maryland</u> | |

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 14 1925

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10333

10325 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|------------------|--|------------------|---|-----------------|--|-------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN <u>Cumberland</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN <u>Cumberland</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | | HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| 102 TOWN <u>Cumberland</u> | | 11 Days | | 109 Federal St. | | 02 | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| Mr. Casper F. Goetz | | | | Nov. 1 19 55 | | | |
| 5. SEX | 6. RACE OR COLOR | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| Male | White | Widowed | Feb. 5, 1884 | 71 yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Ret. Foreman | | Wholesale Groc. | | Maryland, Cumberland | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| John Goetz | | | | Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| (If Yes, give war or dates of service) | | 214-05-9482 | | Memorial Hospital, Cumberland, Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 162X IMMEDIATE CAUSE (A) | | | | | | Interval BETWEEN ONSET AND DEATH | |
| Antecedent Cause(s) DUE TO | | | | | | 6 months | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) | | | | | | | |
| DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| M. | | M. | | | | | |
| 22. I hereby certify that I attended the deceased from <u>July</u> <u>19 54</u> , to <u>Nov</u> <u>19 55</u> , that I last saw the deceased <u>alive on</u> <u>Nov 1</u> <u>19 55</u> , and that death occurred at <u>7:55 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | ADDRESS (Street, city, town, state) | | DATE SIGNED | | | |
| <u>Dr. J. J. Hafer</u> | | <u>133 Virginia Ave, Cumberland, Md</u> | | <u>11/2/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | Nov. 4, 1955 | | Sts. Peter & Pauls Cem | | Cumberland, Maryland | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Nov. 3, 1955</u> | | <u>Walter R. Mantz, M.D.</u> | | <u>John J. Hafer, Cumberland, Maryland</u> | | | |

AND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

•

and Confession

10326

CERTIFICATE OF DEATH

10334

Reg. Dist. No. 4

| | | | | | | | |
|--|------------------|--|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE MARYLAND | | COUNTY ALLEGANY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 02 TOWN CUMBERLAND, MD. | | 39 DAYS | | 02 TOWN CUMBERLAND | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 60 MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES., | | | | 437 SOUTH STREET | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) THURSTON (Middle) F. (Last) GRAPES | | | | (Month) NOV. (Day) 22 (Year) 55 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| MALE | WHITE | MARRIED | 4-7-1894 | 61 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Painter | | Painting | | PIEDMONT, W.VA. | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| JAMES GRAPES | | | | VIRGINIA SOURS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | 214-07-0301 | | Cumberland, Md. Gertrude Viola Grapes | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 581.0 IMMEDIATE CAUSE (A) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | 2 mo | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from 12/14/55, 19 to 11/22/55, 19, that I last saw the deceased alive on 11/22/55, 19, and that death occurred at 12:05 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| H. Lee Silcox M.D. | | | | Cumberland, Md. | | 11/22/55 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| Burial | | 11/26/55 | | Tearcoat Cemetery | | Augusta, W.Va. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE 11/25/1955 | | Winter R. Rautz, M.D. | | H. Lee Silcox | | Cumberland, Md. | |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

CERTIFICATE OF DEATH

Form 10-55

1. NAME OF DECEASED

JAMES EARL RAY

2. SEX

Male

3. AGE

35

4. PLACE OF BIRTH

Memphis, Tennessee

5. RACE

White

6. DATE OF DEATH

April 4, 1968

7. TIME OF DEATH

10:00 AM

8. PLACE OF DEATH

St. Louis, Missouri

9. CAUSE OF DEATH

Shot

10. MANNER OF DEATH

Assault

11. SIGNATURE OF PHYSICIAN

Dr. J. Edgar Hoover

12. SIGNATURE OF REGISTRAR

John Edgar Hoover

13. SIGNATURE OF WITNESS

John Edgar Hoover

BUREAU V. S.

NOV 29 1965

RECEIVED

ENCLOSURE

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY A PHYSICIAN OR A PERSON AUTHORIZED TO SIGN FOR HIM. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILED IN THE APPROPRIATE RECORDS. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY ISSUED TO THE PERSON TO WHOM IT IS DUE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY MAINTAINED IN THE APPROPRIATE RECORDS. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY DESTROYED WHEN IT IS NO LONGER NEEDED.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10335

10366 CERTIFICATE OF DEATH

Reg. Dist. No. 9

| | | | | | | | |
|--|------------------------------|--|---------------------------------------|---|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>22</u> TOWN <u>Frostburg</u> | | LENGTH OF STAY (In this place) <u>1</u> day | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Frostburg</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61</u> <u>Miners Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>Rt. #2, Zihlman</u> | | 1 | |
| 3. NAME OF DECEASED (Type or Print) <u>Nellie</u> (First) <u>Hamilton</u> (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>11</u> <u>13</u> <u>19 55</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>12-31-1887</u> | 9. AGE last birthday <u>68</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Borden Mines, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Jones</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Downton</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mrs. John Conrad, Frostburg</u> <u>127 Hill St.,</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> | | | | | | <u>13 mos.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension Cardio-</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Vascular disease</u> | | | | | | <u>5 yrs.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>9</u> | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>10-1</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>10-1</u> <u>19 55</u> to <u>11-13</u> <u>19 55</u> , that I last saw the deceased alive on <u>11-12</u> <u>19 55</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>A.C. Diehl</u> ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>11/14/55</u> M.D. | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>11-15-55</u> | | NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park, Frostburg</u> | | LOCATION (City, town, or county) (State) <u>Md.</u> | |
| 24. REC'D BY REGISTRAR DATE <u>11-15-55</u> | | REGISTRAR'S SIGNATURE <u>Mrs. Nancy N. Rae</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>B.H. Montesant</u> | | ADDRESS <u>23 E. Main Frostburg, Md.</u> | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

| | | | | | | | |
|--|--|-------------------|--|--|--|---------------------|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY | | Allegany | | STATE | | Md. COUNTY Allegany | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | TOWN | | CITY (If outside corporate limits write RURAL and give nearest town) | | TOWN | |
| Cumberland | | 64 years | | Cumberland | | 22 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS | | | |
| Dead on arrival at the Memorial Hospital. | | | | (If rural, give location) 537 Rose Hill Ave. | | | |
| 3. NAME OF DECEASED: | | (First) | | (Middle) | | (Last) | |
| Merwin | | Roy | | Hast | | Sr. | |
| (Type or Print) | | | | | | | |
| 4. DATE OF DEATH | | (Month) | | (Day) | | (Year) | |
| Nov. 26 | | 19 | | 55 | | | |
| 5. SEX: | | 6. COLOR OR RACE: | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | | 8. DATE OF BIRTH: | |
| Male | | White | | Married | | Feb. 18-1891 | |
| 9. AGE last birthday: | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 64 yrs. | | Months | | Days | | Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY: | | | |
| Deputy Clerk of Allegany Circuit Court | | | | Cumberland, Md. | | | |
| 11. BIRTHPLACE (State or foreign country): | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| U.S.A. | | | | U.S.A. | | | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| Henry Hast | | | | Mary Catherine Berg | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | | | 16. SOCIAL SECURITY No.: | | | |
| No | | | | None | | | |
| (If Yes, give war or dates of service) | | | | 17. INFORMANT & ADDRESS: | | | |
| | | | | (wife) Mrs. Merwin Hast, Cumberland, Md. | | | |

| | | | |
|--|--|----------------------------------|--|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | sudden | |
| 420.1 Immediate cause | | | |
| (a) Cardiac tamponade | | | |
| DUE TO rupture of left ventricle (posterior) | | | |
| (b) Coronary occlusion (left) with | | | |
| Antecedent cause(s) | | | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | | | |
| DUE TO (c) Cardiac hypertrophy | | | |

| | | | | | |
|---|--|--|--|--|--|
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

| | | | | | |
|--|--|-------------------------|--|---|--|
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> | | | | | |
| SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| H.V. Deming M.D. | | DEPUTY MEDICAL EXAMINER | | Nov. 26-1955 | |
| M.D. | | ASSISTANT MEDICAL EXAM. | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | |
| Burial | | Nov. 29, 1955 | | Willcrest Burial Park, Cumberland, Maryland | |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | |
| Nov. 28, 1955 | | Walter R. Frank, M.D. | | Charles L. George, " " | |

BUREAU V. S.

NOV 29 1925

RECEIVED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits 0398

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10337

Reg. Dist.

No. 4

| | | | | | | | |
|--|-----------------------------------|--|---|--|--------------------------------|---|---|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u> | | LENGTH OF STAY (in this place) <u>6 yrs</u> | | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cumberland</u> <u>02</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Memorial Hospital.</u> | | | | STREET ADDRESS (If rural, give location) <u>34 Browning St.</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Lavina R. Herring</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 8 19 55</u> | | | |
| 5. SEX: <u>female</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u> | 8. DATE OF BIRTH: <u>March 11-1894</u> | 9. AGE last birthday: <u>61</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u> | 11. BIRTHPLACE (State or foreign country): <u>Zilthman, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>John Koontz</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Laura Stevens</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY No.: <u>none</u> | | 17. INFORMANT & ADDRESS: <u>(husband) Edgar C. Herring, Cumberland, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| <u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>Coronary sclerosis</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) | | | | | | | <u>sudden</u> <u>about 2</u> <u>years.</u> |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | | 19b. MAJOR FINDING OF OPERATION: | | | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) | | (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>H.V. Deming M.D.</u> | | DATE THEREOF <u>11-11-55</u> | | NAME OF CEMETERY OR CREMATORY <u>St. George's Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Mt. Savage, Maryland</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE REC'D BY LOCAL REG. <u>Nov. 10. 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u> | | 24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u> | |

Scarpelli

RECEIVED

NOV 14 1955

BUREAU V. S.

10329

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

| | | | | | | | |
|--|-------------------------------|--|--------------------------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | STATE PENNA. | | COUNTY BEDFORD | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) CUMBERLAND, | | LENGTH OF STAY (in this place) 3 DAYS | | CITY (If outside corporate limits, write RURAL and give nearest town) SAXTON | | 75x3 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | | STREET ADDRESS (If rural give location) | | ADDRESS | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) ALTA | | (Middle) M | | (Last) HICKES | | (Month) NOV. (Day) 21 (Year) 19 55 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH OCT. 3, 1891 | 9. AGE last birthday 64 yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant in Floral Shop | | 10b. KIND OF BUSINESS OR INDUSTRY Family Ownership | | 11. BIRTHPLACE (State or foreign country) PENNA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ELMER BOWSER | | | | 14. MOTHER'S MAIDEN NAME CLARA OTT | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS Memorial Hospital | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.1 IMMEDIATE CAUSE (A) Cornary Thrombosis | | | | INTERVAL BETWEEN ONSET AND DEATH Short | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Cornary Arterio Sclerosis | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Bronia Cholecystitis | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 11-23-55 , 19 55 , to 11-24-55 , 19 55 that I last saw the deceased alive on 11-24-55 , 19 55 , and that death occurred at 2:25 PM , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE W.F. Williams, M.D. | | | | ADDRESS (Street, city, town, state) Cumbersland, Pa. | | DATE SIGNED 11-22-55 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | DATE THEREOF Nov. 24, 1955 | | NAME OF CEMETERY OR CREMATORY Methodist Cemetery | | LOCATION (City, town, or county) (State) Haiter, R.F.D., Pennsylvania. | |
| 24. REC'D BY REGISTRAR December 23, 1955 | | REGISTRAR'S SIGNATURE Walter R. Frantz, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE Albert M. Masood | | ADDRESS Saxton, Pa. | |

10338

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---------------------------------------|--|--|--|
| 1. NAME OF DECEASED FEMALE WHITE | | 2. AGE 45 YEARS | | 3. SEX FEMALE | | 4. RACE WHITE | |
| 5. DATE OF DEATH OCT. 3, 1941 | | 6. TIME OF DEATH 10:30 AM | | 7. PLACE OF DEATH HOME | | 8. CAUSE OF DEATH HEART DISEASE | |
| 9. DISEASE OR INJURY CORONARY ARTERY DISEASE | | 10. PREVIOUS ILLNESS NONE | | 11. OCCUPATION HOUSEWIFE | | 12. MARITAL STATUS MARRIED | |
| 13. NAME OF PHYSICIAN DR. J. H. SMITH | | 14. NAME OF HOSPITAL BALTIMORE HOSPITAL | | 15. NAME OF NURSE MRS. J. B. WHITE | | 16. NAME OF FUNERAL HOME JOHN B. WHITE & SONS | |
| 17. SIGNATURE OF PHYSICIAN | | 18. SIGNATURE OF HOSPITAL | | 19. SIGNATURE OF NURSE | | 20. SIGNATURE OF FUNERAL HOME | |

BUREAU V. S.

NOV 25 1941

RECEIVED

RECEIVED
BALTIMORE
NOV 25 1941

1. In this corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10339

10330

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

| | | | | | | | |
|--|------------------|---|----------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 02 TOWN <u>Cumberland</u> | | <u>lifetime</u> | | TOWN <u>Cumberland, Maryland</u> | | 02 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 60 <u>Memorial Hospital</u> | | | | <u>57 N. Center St.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) (Middle) (Last) | | | | (Month) (Day) (Year) | | | |
| <u>Ella Jane Hilleary</u> | | | | <u>Nov. 7, 1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>F</u> | <u>W</u> | <u>Married</u> | <u>June 20, 1877</u> | <u>78</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housewife</u> | | <u>Own Home</u> | | <u>Cumberland, Maryland</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Peter J. Kelly</u> | | | | <u>Martha Brennman</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>None</u> | | <u>Mrs. Catherine Dicks 57 N. Center</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> | | | | | | <u>3 hours</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u> | | | | | | <u>?</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Hypertension Vascular Disease</u> | | | | | | <u>?</u> | |
| 265X OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u> | | | | | | <u>10 years</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 1948</u> , to <u>2 Nov. 1955</u> , that I last saw the deceased alive on <u>2 Nov. 1955</u> , and that death occurred at <u>9:55</u> M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>W. Alfred Van Almon</u> | | | | ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u> | | DATE SIGNED <u>7 Nov 55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>11-10-55</u> | | <u>Hillcrest Burial Park</u> | | <u>Cumberland, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Nov. 10, 1955</u> | | <u>Winter R. Frank, M.D.</u> | | <u>James F. Scarpelli</u> | | <u>Cumberland, Md.</u> | |

10330 CERTIFICATE OF DEATH

| | | | | | |
|----------------------------|--|---------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. PLACE OF BIRTH | | 5. OCCUPATION | | 6. MARITAL STATUS | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. CAUSE OF DEATH | |
| 10. PLACE OF DEATH | | 11. SIGNATURE OF DECEASED | | 12. SIGNATURE OF WITNESS | |
| 13. SIGNATURE OF PHYSICIAN | | 14. SIGNATURE OF CLERK | | 15. SIGNATURE OF JUDGE | |
| 16. SIGNATURE OF MINISTER | | 17. SIGNATURE OF CHURCH | | 18. SIGNATURE OF BURIAL | |
| 19. SIGNATURE OF INTERMENT | | 20. SIGNATURE OF FUNERAL | | 21. SIGNATURE OF CEMETERY | |
| 22. SIGNATURE OF BURIAL | | 23. SIGNATURE OF FUNERAL | | 24. SIGNATURE OF CEMETERY | |
| 25. SIGNATURE OF BURIAL | | 26. SIGNATURE OF FUNERAL | | 27. SIGNATURE OF CEMETERY | |
| 28. SIGNATURE OF BURIAL | | 29. SIGNATURE OF FUNERAL | | 30. SIGNATURE OF CEMETERY | |
| 31. SIGNATURE OF BURIAL | | 32. SIGNATURE OF FUNERAL | | 33. SIGNATURE OF CEMETERY | |
| 34. SIGNATURE OF BURIAL | | 35. SIGNATURE OF FUNERAL | | 36. SIGNATURE OF CEMETERY | |
| 37. SIGNATURE OF BURIAL | | 38. SIGNATURE OF FUNERAL | | 39. SIGNATURE OF CEMETERY | |
| 40. SIGNATURE OF BURIAL | | 41. SIGNATURE OF FUNERAL | | 42. SIGNATURE OF CEMETERY | |
| 43. SIGNATURE OF BURIAL | | 44. SIGNATURE OF FUNERAL | | 45. SIGNATURE OF CEMETERY | |
| 46. SIGNATURE OF BURIAL | | 47. SIGNATURE OF FUNERAL | | 48. SIGNATURE OF CEMETERY | |
| 49. SIGNATURE OF BURIAL | | 50. SIGNATURE OF FUNERAL | | 51. SIGNATURE OF CEMETERY | |
| 52. SIGNATURE OF BURIAL | | 53. SIGNATURE OF FUNERAL | | 54. SIGNATURE OF CEMETERY | |
| 55. SIGNATURE OF BURIAL | | 56. SIGNATURE OF FUNERAL | | 57. SIGNATURE OF CEMETERY | |
| 58. SIGNATURE OF BURIAL | | 59. SIGNATURE OF FUNERAL | | 60. SIGNATURE OF CEMETERY | |
| 61. SIGNATURE OF BURIAL | | 62. SIGNATURE OF FUNERAL | | 63. SIGNATURE OF CEMETERY | |
| 64. SIGNATURE OF BURIAL | | 65. SIGNATURE OF FUNERAL | | 66. SIGNATURE OF CEMETERY | |
| 67. SIGNATURE OF BURIAL | | 68. SIGNATURE OF FUNERAL | | 69. SIGNATURE OF CEMETERY | |
| 70. SIGNATURE OF BURIAL | | 71. SIGNATURE OF FUNERAL | | 72. SIGNATURE OF CEMETERY | |
| 73. SIGNATURE OF BURIAL | | 74. SIGNATURE OF FUNERAL | | 75. SIGNATURE OF CEMETERY | |
| 76. SIGNATURE OF BURIAL | | 77. SIGNATURE OF FUNERAL | | 78. SIGNATURE OF CEMETERY | |
| 79. SIGNATURE OF BURIAL | | 80. SIGNATURE OF FUNERAL | | 81. SIGNATURE OF CEMETERY | |
| 82. SIGNATURE OF BURIAL | | 83. SIGNATURE OF FUNERAL | | 84. SIGNATURE OF CEMETERY | |
| 85. SIGNATURE OF BURIAL | | 86. SIGNATURE OF FUNERAL | | 87. SIGNATURE OF CEMETERY | |
| 88. SIGNATURE OF BURIAL | | 89. SIGNATURE OF FUNERAL | | 90. SIGNATURE OF CEMETERY | |
| 91. SIGNATURE OF BURIAL | | 92. SIGNATURE OF FUNERAL | | 93. SIGNATURE OF CEMETERY | |
| 94. SIGNATURE OF BURIAL | | 95. SIGNATURE OF FUNERAL | | 96. SIGNATURE OF CEMETERY | |
| 97. SIGNATURE OF BURIAL | | 98. SIGNATURE OF FUNERAL | | 99. SIGNATURE OF CEMETERY | |
| 100. SIGNATURE OF BURIAL | | 101. SIGNATURE OF FUNERAL | | 102. SIGNATURE OF CEMETERY | |

RECEIVED

RECEIVED

10/14/1955

BUREAU V. 8

10331 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u> | | LENGTH OF STAY (in this place) <u>19 yr. 8mo.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1/X</u> <u>Sylvan Retreat</u> | | STREET ADDRESS (If rural give location) <u>North Mechanic Street</u> | | | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Herbert Charles Hyde</u> | | | | 4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>16</u> (Year) <u>1955</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u> | | 8. DATE OF BIRTH <u>Unknown</u> | |
| 9. AGE last birthday <u>77</u> yrs. | | IF UNDER 1 YEAR Months <u></u> Days <u></u> | | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Henry Hyde</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary ?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>?</u> | | 16. SOCIAL SECURITY NO. <u>?</u> | | 17. INFORMANT & ADDRESS <u>Mrs. Anne Hyde, Valley St. Cumb.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u> | | | | <u>?</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Septicemia</u> | | | | <u>?</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Schizophrenia, paranoid type</u> | | | | <u>1946-8 mo</u> | | | |
| 19a. DATE OF OPERATION <u>?</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>?</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u> | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 2, 1952</u> , to <u>Nov. 16, 1955</u> , that I last saw the deceased alive on <u>Nov. 15, 1955</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>James E. McLean, M.D.</u> | | | | ADDRESS (Street, city, town, state) <u>49 Greene St., 11-16-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Nov. 18, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>Nov. 17, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Kight</u> | | ADDRESS <u>Cumberland, Maryland.</u> | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

10330

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

10330 CERTIFICATE OF DEATH

Form No. 10330

1. FULL NAME OF DECEASED

2. PLACE OF DEATH

3. SEX AND AGE

4. OCCUPATION

5. MARITAL STATUS

6. DATE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. PLACE OF BIRTH

12. PLACE OF DEATH

13. DATE OF BIRTH

14. DATE OF DEATH

15. TIME OF BIRTH

16. TIME OF DEATH

17. PLACE OF BIRTH

18. PLACE OF DEATH

19. DATE OF BIRTH

20. DATE OF DEATH

21. TIME OF BIRTH

22. TIME OF DEATH

23. PLACE OF BIRTH

24. PLACE OF DEATH

25. DATE OF BIRTH

26. DATE OF DEATH

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61. DATE OF BIRTH

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70. TIME OF DEATH

71. PLACE OF BIRTH

72. PLACE OF DEATH

73. DATE OF BIRTH

74. DATE OF DEATH

75. TIME OF BIRTH

76. TIME OF DEATH

77. PLACE OF BIRTH

78. PLACE OF DEATH

79. DATE OF BIRTH

80. DATE OF DEATH

81. TIME OF BIRTH

82. TIME OF DEATH

BUREAU V. S.

NOV 21 1955

RECEIVED

10332

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | CITY <u>Lonaconing</u> | | TOWN <u>X</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN | |
| TOWN <u>Cumberland, Md.</u> | | <u>24 Hours</u> | | STREET ADDRESS | | (If rural give location) | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | <u>Sacred Heart Hospital</u> | | <u>24 W. Main St.</u> | | <u>1</u> | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| <u>William O. Jones</u> | | | | <u>Nov. 15 19 55</u> | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH | |
| <u>Male</u> | | <u>White</u> | | <u>Married</u> | | <u>3/17, -83</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE last birthday | | IF UNDER 1 YEAR | |
| <u>Retired Engineering Dept.</u> | | <u>Employee-Celanese</u> | | <u>72</u> yrs. | | Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| <u>Maryland</u> | | <u>U.S.A.</u> | | <u>Daniel Jones.</u> | | <u>Jean Kirkwood</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>214 - 07 -4111</u> | | <u>Hospital Record</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) | | | | <u>Cerebral Hemorrhage</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | <u>Hypertensive Vascular Disease</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| DUE TO (B) | | | | | | | |
| DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| <u>0</u> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>July 19 52</u> to <u>15 Nov 19 55</u> that I last saw the deceased alive on <u>15 Nov 19 55</u> and that death occurred at <u>6 55 PM</u> from the causes and on the date stated above. SIGNATURE <u>George Richards</u> M.D. ADDRESS <u>Lonaconing Md</u> DATE SIGNED <u>11-15-55</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>11/18/55</u> | | <u>Memorial Park</u> | | <u>Frostburg, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Nov 18, 1955</u> | | <u>Walter R. Prantz, M.D.</u> | | <u>George Eichhorn</u> | | <u>Lonaconing, Md.</u> | |

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1901

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

1. Name of deceased (Print or write full name)

2. Place of death

3. Date of death (Month, day, year)

4. Cause of death (State immediately and briefly)

5. Name and position of attending physician

6. Name and position of medical examiner

7. Name and position of coroner

8. Name and position of registrar

9. Name and position of undertaker

10. Name and position of funeral home

11. Name and position of cemetery

12. Name and position of church

13. Name and position of minister

14. Name and position of sexton

15. Name and position of sexton

NOTIFICATION

1. Name of deceased (Print or write full name)

2. Place of death

3. Date of death (Month, day, year)

4. Cause of death (State immediately and briefly)

5. Name and position of attending physician

6. Name and position of medical examiner

7. Name and position of coroner

8. Name and position of registrar

9. Name and position of undertaker

10. Name and position of funeral home

11. Name and position of cemetery

12. Name and position of church

13. Name and position of minister

14. Name and position of sexton

15. Name and position of sexton

BUREAU V. S.

NOV 31 1901

RECEIVED

BUREAU V. S.

1

10333 CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

| | | | | | | | |
|---|------------------|--|--------------------|---|-----------------|---|-----------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ALLEGANY</u> | | STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | OR TOWN | | OR TOWN | |
| TOWN <u>CUMBERLAND</u> | | <u>7 DAYS</u> | | TOWN <u>OLDTOWN</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,</u> | | | | <u>/</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>MINNIE</u> (Middle) <u>M</u> (Last) <u>KIFER</u> | | | | (Month) <u>NOV.</u> (Day) <u>5</u> (Year) <u>1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | |
| <u>FEMALE</u> | <u>WHITE</u> | <u>WIDOWED Single</u> | <u>MAY 26 1890</u> | <u>65</u> yrs. | Months | Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housewife</u> | | <u>Own Home</u> | | <u>OLDTOWN, MARYLAND</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>GEORGE C. KIFER</u> | | | | <u>MARGARET DILL</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>None</u> | | <u>Memorial Hospital Cumberland, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| <u>422.2</u> IMMEDIATE CAUSE (A) <u>Chronic Nephritis & Uremia</u> | | | | <u>72 hrs</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u> | | | | <u>3 yrs</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Obesity</u> | | | | <u>20 yrs</u> | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| <u>M.</u> | | <u>M.</u> | | | | | |
| 22. I hereby certify that I attended the deceased from <u>11/4/55</u> , 19....., to <u>11/5/55</u> , 19....., that I last saw the deceased alive on <u>11/4/55</u> , 19....., and that death occurred at <u>7:20 AM</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Cumberland Md</u> DATE SIGNED <u>11/5/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, of county) (State) | |
| <u>Burial</u> | | <u>11-7-55</u> | | <u>Mt. Olive Cemetery</u> | | <u>Near Oldtown Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>Nov. 7, 1955</u> | | <u>Walter R. Drantz MD</u> | | <u>Louis Stein Inc.,</u> | | <u>Cumberland Md.</u> | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1038 CERTIFICATE OF DEATH

(1)

CYANIDE

2034

3704

11

06-1798, 127-10

GEORGE C. RIFE

10334 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

| | | | | | | | |
|---|-------------------------------|--|--------------------------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | |
| CITY OR TOWN <u>Cumberland</u> | | LENGTH OF STAY (in this place) <u>29 Years</u> | | STREET ADDRESS <u>504. Columbia Ave</u> | | STREET ADDRESS (If rural give location) <u>504. Columbia Ave</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>504. Columbia Ave</u> | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Frances</u> | | (Middle) <u>Elizabeth</u> | | (Last) <u>Kreger</u> | | (Month) <u>Nov</u> (Day) <u>19</u> (Year) <u>19 55</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u> | 8. DATE OF BIRTH <u>July 20 1879</u> | 9. AGE last birthday <u>76</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| | | | | Months | | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>? Penna</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Edward Lungenfelter</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Clevenger</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mrs. Betty Stitcher Cumberland Md.</u> | | | |
| | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 450.0 IMMEDIATE CAUSE (A) <u>Arteriosclerosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>UNDERLYING CAUSE LAST.</u> | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>0</u> | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 20c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 20d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 20e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov 1</u> , 19 <u>55</u> , to <u>Nov 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 18</u> , 19 <u>55</u> , and that death occurred at <u>2:50 P</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Lesley Dr.</u> | | | | ADDRESS (Street, city, town, state) <u>M.D. 456 N. Centre St.</u> | | | |
| DATE SIGNED <u>11/20/55</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Nov 22 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Jersey Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Confluence, Pa.</u> | |
| 24. REC'D BY REGISTRAR <u>Nov 24, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter F. Bantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight,</u> | | ADDRESS <u>Cumberland, Md.</u> | |

1033

RECEIVED STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1033A CERTIFICATE OF DEATH

Each Death No.

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. MARITAL STATUS

9. US BORN

10. DATE OF DEATH

11. PLACE OF DEATH

12. CAUSE OF DEATH

13. MANNER OF DEATH

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF DECEASED

18. SIGNATURE OF NEXT OF KIN

19. SIGNATURE OF BURIAL OFFICIAL

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF CLERK

22. SIGNATURE OF OFFICIAL

23. SIGNATURE OF DECEASED

24. SIGNATURE OF NEXT OF KIN

25. SIGNATURE OF BURIAL OFFICIAL

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF CLERK

28. SIGNATURE OF OFFICIAL

29. SIGNATURE OF DECEASED

30. SIGNATURE OF NEXT OF KIN

31. SIGNATURE OF BURIAL OFFICIAL

32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF CLERK

34. SIGNATURE OF OFFICIAL

35. SIGNATURE OF DECEASED

36. SIGNATURE OF NEXT OF KIN

37. SIGNATURE OF BURIAL OFFICIAL

38. SIGNATURE OF INTERVIEWER

39. SIGNATURE OF CLERK

40. SIGNATURE OF OFFICIAL

41. SIGNATURE OF DECEASED

42. SIGNATURE OF NEXT OF KIN

43. SIGNATURE OF BURIAL OFFICIAL

44. SIGNATURE OF INTERVIEWER

45. SIGNATURE OF CLERK

46. SIGNATURE OF OFFICIAL

47. SIGNATURE OF DECEASED

48. SIGNATURE OF NEXT OF KIN

49. SIGNATURE OF BURIAL OFFICIAL

50. SIGNATURE OF INTERVIEWER

51. SIGNATURE OF CLERK

52. SIGNATURE OF OFFICIAL

53. SIGNATURE OF DECEASED

54. SIGNATURE OF NEXT OF KIN

55. SIGNATURE OF BURIAL OFFICIAL

56. SIGNATURE OF INTERVIEWER

57. SIGNATURE OF CLERK

58. SIGNATURE OF OFFICIAL

59. SIGNATURE OF DECEASED

60. SIGNATURE OF NEXT OF KIN

61. SIGNATURE OF BURIAL OFFICIAL

62. SIGNATURE OF INTERVIEWER

63. SIGNATURE OF CLERK

64. SIGNATURE OF OFFICIAL

65. SIGNATURE OF DECEASED

66. SIGNATURE OF NEXT OF KIN

67. SIGNATURE OF BURIAL OFFICIAL

68. SIGNATURE OF INTERVIEWER

69. SIGNATURE OF CLERK

70. SIGNATURE OF OFFICIAL

71. SIGNATURE OF DECEASED

72. SIGNATURE OF NEXT OF KIN

73. SIGNATURE OF BURIAL OFFICIAL

74. SIGNATURE OF INTERVIEWER

75. SIGNATURE OF CLERK

76. SIGNATURE OF OFFICIAL

77. SIGNATURE OF DECEASED

78. SIGNATURE OF NEXT OF KIN

79. SIGNATURE OF BURIAL OFFICIAL

80. SIGNATURE OF INTERVIEWER

81. SIGNATURE OF CLERK

82. SIGNATURE OF OFFICIAL

83. SIGNATURE OF DECEASED

84. SIGNATURE OF NEXT OF KIN

85. SIGNATURE OF BURIAL OFFICIAL

86. SIGNATURE OF INTERVIEWER

87. SIGNATURE OF CLERK

88. SIGNATURE OF OFFICIAL

89. SIGNATURE OF DECEASED

90. SIGNATURE OF NEXT OF KIN

91. SIGNATURE OF BURIAL OFFICIAL

92. SIGNATURE OF INTERVIEWER

93. SIGNATURE OF CLERK

94. SIGNATURE OF OFFICIAL

95. SIGNATURE OF DECEASED

96. SIGNATURE OF NEXT OF KIN

97. SIGNATURE OF BURIAL OFFICIAL

98. SIGNATURE OF INTERVIEWER

99. SIGNATURE OF CLERK

100. SIGNATURE OF OFFICIAL

99. SIGNATURE OF DECEASED

100. SIGNATURE OF NEXT OF KIN

101. SIGNATURE OF BURIAL OFFICIAL

100. SIGNATURE OF INTERVIEWER

101. SIGNATURE OF CLERK

102. SIGNATURE OF OFFICIAL

101. SIGNATURE OF DECEASED

102. SIGNATURE OF NEXT OF KIN

103. SIGNATURE OF BURIAL OFFICIAL

102. SIGNATURE OF INTERVIEWER

103. SIGNATURE OF CLERK

104. SIGNATURE OF OFFICIAL

103. SIGNATURE OF DECEASED

104. SIGNATURE OF NEXT OF KIN

105. SIGNATURE OF BURIAL OFFICIAL

104. SIGNATURE OF INTERVIEWER

105. SIGNATURE OF CLERK

106. SIGNATURE OF OFFICIAL

105. SIGNATURE OF DECEASED

106. SIGNATURE OF NEXT OF KIN

107. SIGNATURE OF BURIAL OFFICIAL

106. SIGNATURE OF INTERVIEWER

107. SIGNATURE OF CLERK

108. SIGNATURE OF OFFICIAL

107. SIGNATURE OF DECEASED

108. SIGNATURE OF NEXT OF KIN

109. SIGNATURE OF BURIAL OFFICIAL

BUREAU V. 5

101 10 1955

RECEIVED

NOTIFICATION

NOTIFICATION OF DEATH TO BE FURNISHED TO THE NEAREST RELATIVE OR TO THE NEXT OF KIN, OR TO THE PERSON IN CHARGE OF THE BURIAL, AND TO THE LOCAL HEALTH DEPARTMENT, AND TO THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.

1 Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr. Weisman

10335 CERTIFICATE OF DEATH

10344

Reg. Dist. No. **4**

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Cumberland</u> | | <u>37 Days</u> | | TOWN <u>Cumberland</u> | | <u>02</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>60 Memorial Hospital</u> | | | | <u>100 Independence Street</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>John</u> <u>Laber</u> | | | | <u>11-13-55</u> | | | |
| 5. SEX | | 6. COLOR OR | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH | |
| <u>Male</u> | | <u>White</u> | | <u>Widowed</u> | | <u>November 21 1875</u> <u>79</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Retired Janitor</u> | | <u>Celenese Corp</u> | | <u>Maryland</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>John Laber</u> | | | | <u>Margaret Glodhart</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>217-10-4468</u> | | <u>Mrs. Bessie Myers, Cumberland, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| <u>581.0 CIRRHOSIS OF THE LIVER</u> | | | | <u>UNKNOWN</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (B) | | | | | | | |
| <u>20 Chronic Cholelithiasis</u> | | | | <u>UNKNOWN</u> | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH | | | | <u>(2) ARTERIOSCLEROTIC HEART DISEASE</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | | |
| <u>2</u> | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office-bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) | | 21a. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| | | While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | <u>Slipped on</u> | | | |
| | | <u>M.</u> | | | | | |
| 22. I hereby certify that I attended the deceased from <u>11 A.M.</u>, 19<u>55</u>, to <u>13 Nov.</u>, 19<u>55</u>, that I last saw the deceased alive on <u>13 Nov.</u>, 19<u>55</u>, and that death occurred at <u>5:43P.</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| <u>Deville G. Weisman</u> | | | | <u>54 Green St. Cumberland, Md.</u> | | <u>16 Nov 1955</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Nov 16 1955</u> | | <u>Frostburg Memorial Cem</u> | | <u>Frostburg, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Nov 17, 1955</u> | | <u>Walter R. Frantz, M.D.</u> | | <u>William H. Kight,</u> | | <u>Cumberland, Md.</u> | |

10345

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

10336

| | | | | | | | |
|--|------------------|--|------------------|---|--------------------------------------|--|------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> | | LENGTH OF STAY (in this place) <u>46 hrs</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Rural</u> | | TOWN <u>02 Cumberland Rural</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 Sacred Heart Hospital</u> | | | | STREET ADDRESS <u>P.O. # 5 Cumberland</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) (Middle) (Last) <u>(Mrs.) Clara B. Lafferty</u> | | | | Month Day Year <u>11 7 19 55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. | | |
| <u>Female</u> | <u>White</u> | <u>Married</u> | <u>11-2-85</u> | <u>70</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland - Alleg Co.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | |
| 13. FATHER'S NAME <u>John T. Finley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>HARRIET STARKY</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT & ADDRESS <u>Jacob W. Lafferty, Cumberland, Md</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.0 IMMEDIATE CAUSE (A) <u>Acute Myocardial Failure</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Infarction</u> | | | | <u>7 days</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Heart Disease</u> | | | | <u>7 years</u> | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Nephrosclerosis</u> <u>terminal Diabetes mellitus</u> | | | | <u>3 days</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office-bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>1948</u> , to <u>7 Nov.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7 Nov.</u> , 19 <u>55</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>AG Weesman M.D.</u> | | | | DATE SIGNED <u>10/9/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Nov. 10, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Eckhart, Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>Nov. 10, 1955</u> | | REGISTRAR'S SIGNATURE <u>Winter L. Grant, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hager</u> | | ADDRESS <u>Cumberland, Md.</u> | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

10348

CERTIFICATE OF DEATH

10388

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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BUREAU V. 2

NOV 14 1955

RECEIVED

RECEIVED

RECEIVED
BUREAU OF VITAL STATISTICS
U.S. DEPARTMENT OF HEALTH
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10340
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

| | | | |
|--|--------------------------------|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Md.</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cumberland</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12 Humbird St.</u> | | STREET ADDRESS (If rural, give location) <u>12 Humbird St.</u> | |
| 3. NAME OF DECEASED: | | 4. DATE OF DEATH | |
| (First) <u>Marion</u> | (Middle) <u>Laley</u> | (Last) | (Month) <u>Nov.</u> (Day) <u>8</u> (Year) <u>1955</u> |
| 5. SEX: <u>Female</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u> | 8. DATE OF BIRTH: <u>Jan. 13-1877</u> |
| 9. AGE last birthday: <u>78</u> yrs. | | 10. BIRTHPLACE (State or foreign country): <u>Md.</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Town Creek, Allegany Co. U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME: <u>James Laley</u> | | 14. MOTHER'S MAIDEN NAME: <u>Ellen Athey</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY No.: | |
| 17. INFORMANT & ADDRESS: <u>Mrs. George Athey-115 Humbird St. City</u> | | | |

| | | |
|---|--|---|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | |
| <p>Immediate cause (a) <u>Shock also burns, 3rd. & 4th. degree of body.</u></p> <p>Antecedent cause(s) (b) <u>Dress caught fire from a gas plate.</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p> | | |

| | |
|---|--|
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | |
|---|--|

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION: <u>Nov. 8-1955 P.M.</u> | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 21c. (City or town) <u>Cumberland</u> (County) <u>Allegany</u> (State) <u>Md.</u> | |
| 21d. TIME (Month) <u>Nov.</u> (Day) <u>8</u> (Year) <u>1955</u> (Hour) <u>P.M.</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Dress caught fire from a gas plate in kitchen.</u> | |

| | |
|---|--|
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | |
| SIGNATURE <u>H.V. Dening M.D.</u> <u>H.V. Dening M.D.</u> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Nov. 9-1955</u> | |

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF <u>Nov. 12, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery, Cumberland, Maryland</u> | | LOCATION (City, town, or county) (State) | |
| DATE REC'D BY LOCAL REG. <u>Nov. 14, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u> | | 24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Maryland</u> | | ADDRESS | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 14 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10347
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> | | LENGTH OF STAY (in this place) <u>40 years</u> | | CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Cumberland</u> | | <u>02</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>216 New Hampshire Ave</u> | | | | STREET ADDRESS (If rural, give location) <u>216 New Hampshire Ave.</u> | | | |
| 3. NAME OF DECEASED: (First) <u>Ella</u> | | (Middle) <u>May</u> | | (Last) <u>Lewis</u> | | 4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>26</u> (Year) <u>1955</u> | |
| 5. SEX: <u>female</u> | | 6. COLOR OR RACE: <u>white</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u> | | 8. DATE OF BIRTH: <u>Feb. 23-1875</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u> | | 9. AGE last birthday: <u>80</u> yrs. | | 11. BIRTHPLACE (State or foreign country): <u>Brunswick, Md.</u> | |
| 13. FATHER'S NAME: <u>Cyrus H. Fisher</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Laura Barger</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY No.: <u>none</u> | | 17. INFORMANT & ADDRESS: <u>216 New Hampshire Ave. (son) Edwin D. Lewis, Cumberland, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| Immediate cause (a) <u>Myocardial failure</u> | | | | | | <u>sudden</u> | |
| Antecedent cause(s) (b) <u>Cardio-vascular-renal disease.</u> | | | | | | <u>?</u> | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH | | | | | | | |
| 19a. DATE OF OPERATION: <u>Nov. 28, 1955</u> | | 19b. MAJOR FINDING OF OPERATION: | | | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) | | (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | | DATE SIGNED | |
| <u>H.V. Deming M.D.</u> | | <u>Restland Burial Park</u> | | <u>Cumberland, Maryland</u> | | <u>Nov. 26-1955</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF: <u>Nov. 29, 1955</u> | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| DATE REC'D BY LOCAL REG. <u>Nov. 28, 1955</u> | | REGISTRAR'S SIGNATURE: <u>Walter R. Hartz, M.D.</u> | | <u>John J. Safes</u> | | <u>"</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 29 1935

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10348

Within corporate limits

1033 CERTIFICATE OF DEATH

DR. W.F. WILLIAMS

Reg. Dist. No. 4

| | | | | | | | |
|---|--|---|--|---|--|---|---------------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | STATE MARYLAND | | COUNTY ALLEGANY | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND | | LENGTH OF STAY (in this place) 53 DAYS | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LA VALE | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL | | STREET ADDRESS (If rural give location) 250 NATIONAL HIGHWAY | | | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) ALICE LITZENBURG | | | | 4. DATE OF DEATH (Month) (Day) (Year) NOV. 13, 1955 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH DECEMBER 7, 1878 | 9. AGE last birthday 76 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House W. Fa</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Penn.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>US A.</i> | |
| 13. FATHER'S NAME FRANK GILCRIST | | | | 14. MOTHER'S MAIDEN NAME MARY EARNEST | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Yes</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD. | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i> | | | | | | <i>Sept 29</i> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive Arterio-sclerosis</i> | | | | | | <i>1955</i> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <i>Ischemic disease</i> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 6:22, 1955, to 11-13, 1955, that I last saw the deceased alive on 11-12, 1955, and that death occurred at 4:35 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>W.F. Williams</i> M.D. | | | | ADDRESS (Street, city, town, state) <i>Cumberland Md</i> | | DATE SIGNED <i>11-14-55</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i> | DATE THEREOF <i>11/15/55</i> | NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i> | | LOCATION (City, town, or county) (State) <i>Cumberland Md</i> | | | |
| 24. REC'D BY REGISTRAR DATE <i>11-15-55</i> | REGISTRAR'S SIGNATURE <i>Walter R. Trout</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>James H. H. H.</i> | | ADDRESS <i>Cumberland Md</i> | | |

RECEIVED

NOV 16 1955

BUREAU V. S.

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| 1033CERTIFICATE OF DEATH | |
| MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19 | |
| 103338 | |
| MR. W. J. WILLIAMS | |
| 1. PLACE OF BIRTH | |
| 2. DATE OF BIRTH | |
| 3. SEX | |
| 4. RACE | |
| 5. OCCUPATION | |
| 6. MARITAL STATUS | |
| 7. PLACE OF DEATH | |
| 8. DATE OF DEATH | |
| 9. TIME OF DEATH | |
| 10. CAUSE OF DEATH | |
| 11. MANNER OF DEATH | |
| 12. SIGNATURE | |
| 13. DATE | |
| 14. PLACE | |
| 15. NAME | |
| 16. ADDRESS | |
| 17. CITY | |
| 18. STATE | |
| 19. ZIP CODE | |
| 20. TELEPHONE | |
| 21. FAX | |
| 22. E-MAIL | |
| 23. OTHER | |
| 24. COMMENTS | |
| 25. SIGNATURE | |
| 26. DATE | |
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| 701. SIGNATURE | |
| 702. DATE | |
| 703. PLACE | |
| 704. NAME | |
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INSTRUCTIONS

VS A15C 1-55 10M

Items 1.2.FilmG189 11-16-55 et

~~William~~ corpore

40340

CERTIFICATE OF DEATH

10349

Reg. Dist. No.

| | | | |
|--|--------------------------------|--|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>ALLEGANY</u> | MARYLAND | STATE <u>MARYLAND</u> | COUNTY <u>ALLEGANY</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (In this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| 02 TOWN <u>CUMBERLAND (Near)</u> | 26 days | OR TOWN <u>Cumberland-Rural</u> | X |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| 62 <u>SACRED HEART HOSPITAL</u> | | 21 FURNACE STREET | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH (Month) (Day) (Year) | |
| (First) (Middle) (Last) | | 11-7-55 19 | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH |
| M | W | Widowed | 7-1-72 |
| 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS | |
| 83 yrs. | Months Days | Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) |
| | | | Maryland |
| 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| JOHN LOCHNER | | MARY FRATZ | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| | | CHART | |
| 17. INFORMANT & ADDRESS | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.0 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> | | 30 min | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u> | | 3 year | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Lobar Pneumonia</u> | | 4 weeks | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>11-7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-7</u> , 19 <u>55</u> , and that death occurred at <u>7:15</u> P.M. from the causes and on the date stated above. | | | |
| SIGNATURE <u>George R. Schantz</u> | | ADDRESS (Street, city, town, state) <u>Livingston, Md</u> | |
| DATE <u>Nov. 7, 1955</u> | | DATE SIGNED <u>11-7-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Walter R. Drant</u> | |
| DATE THEREOF <u>11-10-55</u> | | NAME OF CEMETERY OR CREMATORY <u>Frederick Memorial Park</u> | |
| LOCATION (City, town, or county) <u>Frederick Md.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Ellenmaich S. Baal</u> | |
| | | ADDRESS <u>Wentzville</u> | |

CERTIFICATE OF DEATH

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

NAME OF DECEASED

AGE

SEX
MARRIED
SINGLE
WIDOWED
DIVORCED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. 2

NOV 10 1955

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DEPARTMENT OF HEALTH
 MISSISSIPPI
 BUREAU OF VITAL RECORDS
 1000 NORTH GADSDEN AVENUE
 JACKSON, MISSISSIPPI 39201
 PHONE 462-1111
 TELETYPE 462-1111
 CABLE 462-1111
 POSTAL ADDRESS: JACKSON, MISSISSIPPI 39201

Outside of City Limits

10376

10350

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

| | | | |
|---|---|---|---------------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Md.</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>X TOWN Rural) Cumberland</u> | LENGTH OF STAY (in this place) <u>8 yrs.</u> | CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Rural) Cumberland</u> | <u>X</u> |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route # 6</u> | | STREET ADDRESS (If rural, give location) <u>Route #6</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mildred Virginia Lynch</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 7 19 55</u> | |
| 5. SEX: <u>female</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u> | 8. DATE OF BIRTH: <u>Dec. 23-1907</u> |
| 9. AGE last birthday: <u>47</u> yrs. | | 10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>homemstress</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Metro Store</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Cumberland, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Louis Lee</u> | | 14. MOTHER'S MAIDEN NAME: <u>Margaret Hendrickson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO.: <u>214-05-6880</u> | |
| 17. INFORMANT & ADDRESS: (husband) <u>Michael Patrick Lynch, Rt. 6</u> | | | |

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| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | |
| <u>422.2</u> <u>Immediate cause</u> (a) <u>Acute cardiac failure</u> DUE TO <u>Antecedent cause(s)</u> (b) <u>Chronic myocarditis</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) | | |

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| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |
| 19a. DATE OF OPERATION: <u>0</u> | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) (County) (State) |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐ , Inspection ☒ , Inquiry ☒ , and find that death resulted from: Natural causes ☒ , Accident ☐ , Suicide ☐ , Homicide ☐ , Undetermined cause ☐ .
 SIGNATURE H.V. Deming M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Nov. 7-1955
H.V. Deming M.D. DEPUTY MEDICAL EXAMINER ☒ M. D. ASSISTANT MEDICAL EXAM. ☐

| | | | |
|---|---|--|---|
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | DATE THEREOF: <u>11-10-55</u> | NAME OF CEMETERY OR CREMATORY: <u>St. Peter & Pauls Cemetery</u> | LOCATION (City, town, or county) (State): <u>Cumberland, Maryland</u> |
| DATE REC'D BY LOCAL REG. <u>Nov. -10-55</u> | REGISTRAR'S SIGNATURE: <u>Walter R. Pranty M.D.</u> | 24. FUNERAL DIRECTOR: <u>John J. Hafer, Cumberland, Md</u> | ADDRESS: <u>Hafer</u> |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 14 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Dr Grove

10341

Within corporate limits

CERTIFICATE OF DEATH

10351

Reg. Dist. No. 4

| | | | | | | | |
|--|----------------------------------|--|--|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>W. Va.</u> | | COUNTY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Cumberland</u> | | <u>3 Days</u> | | TOWN <u>Ridgeley</u> | | <u>85 x -3</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>Route #1</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>Henry Washington Malone</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>11-13 1955</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Dec. 11, 1881</u> | 9. AGE last birthday <u>73</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired carmans helper B. & O. Rwy.</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Patterson Creek, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME <u>Michael M Malone</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Alice Alkire</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>705-07-9760</u> | | 17. INFORMANT & ADDRESS <u>Mrs. Sally Malone Fort Ashby, W. Va.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>587.0 Directing aneurysm of aorta</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| ANTECEDENT CAUSE(S) (B) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Acute hemorrhagic gastroenteritis</u> | | | | | | <u>6 days</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Purulent bronchitis</u> | | | | | | <u>2 days</u> | |
| 19a. DATE OF OPERATION <u>2/10/56</u> | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>11-10</u> , 19 <u>55</u> , to <u>11-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-13</u> , 19 <u>55</u> , and that death occurred at <u>3:38 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | | | ADDRESS (Street, city, town, state) <u>M.D. 22 S. Centre St., Cumberland, Md 21-14-55</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>11/15/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Malone Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Near Fort Ashby, W. Va.</u> | |
| 24. REC'D BY REGISTRAR DATE <u>11-15-55</u> | | REGISTRAR'S SIGNATURE <u>W.R. Trouty, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Charles L. George Cumberland, Md.</u> | | | |

1951 CERTIFICATE OF DEATH

10871

Rev. Code, 1950

1. NAME OF DECEASED (Print or Type)

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. MARITAL STATUS

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

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BUREAU V. 8

NOV 16 1955

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1. NAME OF DECEASED (Print or Type)
2. PLACE OF DEATH
3. SEX
4. AGE
5. DATE OF DEATH
6. TIME OF DEATH
7. PLACE OF BIRTH
8. OCCUPATION
9. MARITAL STATUS
10. CAUSE OF DEATH
11. MANNER OF DEATH
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INSTRUCTIONS

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10352

10342 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY ALLEGANY | MARYLAND | STATE MARYLAND | COUNTY ALLEGANY |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND | LENGTH OF STAY (in this place) 11 DAYS | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | | STREET ADDRESS (If rural give location) 28 FIFTH STREET | |
| 3. NAME OF DECEASED (First) (Middle) (Last) LILLIAN P MILLER | | 4. DATE OF DEATH (Month) (Day) (Year) NOV 29 1955 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH OCTOBER 15 1898 |
| 9. AGE last birthday 57 yrs. | | 10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS (Hours) (Min.) | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Preparation Auto Rubber Tire Plant-Cumberland | | 10b. KIND OF BUSINESS OR INDUSTRY USA | |
| 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME THOMAS REDEXX TROXELL | | 14. MOTHER'S MAIDEN NAME JAMIMA ROBINETTE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-07-0008 | |
| 17. INFORMANT & ADDRESS Joseph T. Miller 28 5th St. | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| 241X IMMEDIATE CAUSE (A) Chronic Myocarditis & Decompensation | | INTERVAL BETWEEN ONSET AND DEATH 5 wks | |
| ANTECEDENT CAUSE(S) DUE TO (B) Bronchial Asthma | | 12 yrs | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Sub-acute Nephritis | | 5 wks | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Oct 10, 1955 to Nov 29, 1955 , that I last saw the deceased alive on Nov 29, 1955 , and that death occurred at 4:01 P.M. from the causes and on the date stated above. | | | |
| SIGNATURE Clay E. Lurrett | | ADDRESS (Street, city, town, state) Cumberland, Md | |
| DATE SIGNED 11/29/55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 12-2-55 | |
| NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | | LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 24. REC'D BY REGISTRAR Dec 2, 1955 | | REGISTRAR'S SIGNATURE Walter R. Hunt, M.D. | |
| 25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli | | ADDRESS Cumberland | |

SECRET

DEC 5 1955

RECEIVED

Outside of
City limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10353

10377 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. The top copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY OR TOWN <u>Rural Cumberland</u> | | LENGTH OF STAY (in this place) <u>25 years</u> | | TOWN <u>Rural Cumberland</u> | | STREET ADDRESS (If rural give location) | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Baltimore Pike</u> | | | | STREET ADDRESS <u>Baltimore Pike, R.F.D. #2</u> | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Margaret Elizabeth Miller</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 23 19 55</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>July 13, 1905</u> | 9. AGE last birthday <u>50</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper at Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George E. Hardmag</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Arlintha Mann</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>330-86-9230</u> | | 17. INFORMANT & ADDRESS <u>Walter T. Miller Cumberland, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 170X IMMEDIATE CAUSE (A) <u>Brain Tumor (Carcinoma)</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of Breast (metastatic)</u> | | | | <u>4 yrs.</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>0</u> | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>55</u> , to <u>Nov</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 23</u> , 19 <u>55</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Benedict Skutarelis</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>R² Cumberland, Md.</u> DATE SIGNED | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>11/27/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cem.</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| 24. REC'D BY REGISTRAR <u>Nov. 27, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u> | | ADDRESS <u>Cumberland, Md.</u> | |

BUREAU V. S.

62 AON

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8, Film C189 11-16-55 et

10354

10343

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|------------------|--|---------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | STATE MARYLAND | | COUNTY ALLEGANY | | | |
| CITY (If outside corporate limits, write RURAL or give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 4 DAYS | | TOWN CUMBERLAND R. D. # 6 | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| MEMORIAL HOSPITAL MEMORIAL AVE. | | | | Locust Grove | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) MR MICHAEL (Middle) Henry (Last) MILLER | | | | (Month) NOV. (Day) 3 (Year) 19 55 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| MALE | WHITE | MARRIED | JUNE 17 1885 | 70 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Painter | | Memorial Hosp. | | PENNSYLVANIA | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| PETER MILLER | | | | EAST ANN PRICE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | 212-18-1792 | | MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 451X IMMEDIATE CAUSE (A) far advanced Arterio sclerotic | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) cardio vascular disease (Uremia) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Aortic aneurysm (abdominal) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? | |
| 1/19/55 | | at time, Aneurysm found | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from 10:30, 19 55 , to 11-3-, 19 55 , that I last saw the deceased alive on 11-3-, 19 55 , and that death occurred at 4:20PM , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE W. J. Williams M.D. | | | | ADDRESS (Street, city, town, state) Cumberland Md | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| burial | | 11/6/55 | | Rose Hill Cemetery | | Cumberland, Md. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE Nov. 6, 1955 | | Walter R. Drantz, M.D. | | Charles L. George | | Cumberland, Md. | |

100-100000

RECEIVED
JAN 10 1953
U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF RECORDS AND STATISTICS
WASHINGTON, D.C. 20001

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

100324

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED PETER BLUMEN | | 2. SEX MALE | | 3. RACE WHITE | | 4. DATE OF BIRTH 1922 | | 5. PLACE OF BIRTH NEW YORK, N.Y. | |
| 6. DATE OF DEATH NOV 10 1952 | | 7. PLACE OF DEATH NEW YORK, N.Y. | | 8. CAUSE OF DEATH Heart - (probable) (Coronary) | | 9. MANNER OF DEATH NATURAL | | 10. SIGNATURE OF DECEASED Peter Blumen | |
| 11. SIGNATURE OF WITNESSES John J. ... | | 12. SIGNATURE OF DECEASED Peter Blumen | | 13. SIGNATURE OF DECEASED Peter Blumen | | 14. SIGNATURE OF DECEASED Peter Blumen | | 15. SIGNATURE OF DECEASED Peter Blumen | |
| 16. SIGNATURE OF DECEASED Peter Blumen | | 17. SIGNATURE OF DECEASED Peter Blumen | | 18. SIGNATURE OF DECEASED Peter Blumen | | 19. SIGNATURE OF DECEASED Peter Blumen | | 20. SIGNATURE OF DECEASED Peter Blumen | |
| 21. SIGNATURE OF DECEASED Peter Blumen | | 22. SIGNATURE OF DECEASED Peter Blumen | | 23. SIGNATURE OF DECEASED Peter Blumen | | 24. SIGNATURE OF DECEASED Peter Blumen | | 25. SIGNATURE OF DECEASED Peter Blumen | |
| 26. SIGNATURE OF DECEASED Peter Blumen | | 27. SIGNATURE OF DECEASED Peter Blumen | | 28. SIGNATURE OF DECEASED Peter Blumen | | 29. SIGNATURE OF DECEASED Peter Blumen | | 30. SIGNATURE OF DECEASED Peter Blumen | |
| 31. SIGNATURE OF DECEASED Peter Blumen | | 32. SIGNATURE OF DECEASED Peter Blumen | | 33. SIGNATURE OF DECEASED Peter Blumen | | 34. SIGNATURE OF DECEASED Peter Blumen | | 35. SIGNATURE OF DECEASED Peter Blumen | |
| 36. SIGNATURE OF DECEASED Peter Blumen | | 37. SIGNATURE OF DECEASED Peter Blumen | | 38. SIGNATURE OF DECEASED Peter Blumen | | 39. SIGNATURE OF DECEASED Peter Blumen | | 40. SIGNATURE OF DECEASED Peter Blumen | |
| 41. SIGNATURE OF DECEASED Peter Blumen | | 42. SIGNATURE OF DECEASED Peter Blumen | | 43. SIGNATURE OF DECEASED Peter Blumen | | 44. SIGNATURE OF DECEASED Peter Blumen | | 45. SIGNATURE OF DECEASED Peter Blumen | |
| 46. SIGNATURE OF DECEASED Peter Blumen | | 47. SIGNATURE OF DECEASED Peter Blumen | | 48. SIGNATURE OF DECEASED Peter Blumen | | 49. SIGNATURE OF DECEASED Peter Blumen | | 50. SIGNATURE OF DECEASED Peter Blumen | |
| 51. SIGNATURE OF DECEASED Peter Blumen | | 52. SIGNATURE OF DECEASED Peter Blumen | | 53. SIGNATURE OF DECEASED Peter Blumen | | 54. SIGNATURE OF DECEASED Peter Blumen | | 55. SIGNATURE OF DECEASED Peter Blumen | |
| 56. SIGNATURE OF DECEASED Peter Blumen | | 57. SIGNATURE OF DECEASED Peter Blumen | | 58. SIGNATURE OF DECEASED Peter Blumen | | 59. SIGNATURE OF DECEASED Peter Blumen | | 60. SIGNATURE OF DECEASED Peter Blumen | |
| 61. SIGNATURE OF DECEASED Peter Blumen | | 62. SIGNATURE OF DECEASED Peter Blumen | | 63. SIGNATURE OF DECEASED Peter Blumen | | 64. SIGNATURE OF DECEASED Peter Blumen | | 65. SIGNATURE OF DECEASED Peter Blumen | |
| 66. SIGNATURE OF DECEASED Peter Blumen | | 67. SIGNATURE OF DECEASED Peter Blumen | | 68. SIGNATURE OF DECEASED Peter Blumen | | 69. SIGNATURE OF DECEASED Peter Blumen | | 70. SIGNATURE OF DECEASED Peter Blumen | |
| 71. SIGNATURE OF DECEASED Peter Blumen | | 72. SIGNATURE OF DECEASED Peter Blumen | | 73. SIGNATURE OF DECEASED Peter Blumen | | 74. SIGNATURE OF DECEASED Peter Blumen | | 75. SIGNATURE OF DECEASED Peter Blumen | |
| 76. SIGNATURE OF DECEASED Peter Blumen | | 77. SIGNATURE OF DECEASED Peter Blumen | | 78. SIGNATURE OF DECEASED Peter Blumen | | 79. SIGNATURE OF DECEASED Peter Blumen | | 80. SIGNATURE OF DECEASED Peter Blumen | |
| 81. SIGNATURE OF DECEASED Peter Blumen | | 82. SIGNATURE OF DECEASED Peter Blumen | | 83. SIGNATURE OF DECEASED Peter Blumen | | 84. SIGNATURE OF DECEASED Peter Blumen | | 85. SIGNATURE OF DECEASED Peter Blumen | |
| 86. SIGNATURE OF DECEASED Peter Blumen | | 87. SIGNATURE OF DECEASED Peter Blumen | | 88. SIGNATURE OF DECEASED Peter Blumen | | 89. SIGNATURE OF DECEASED Peter Blumen | | 90. SIGNATURE OF DECEASED Peter Blumen | |
| 91. SIGNATURE OF DECEASED Peter Blumen | | 92. SIGNATURE OF DECEASED Peter Blumen | | 93. SIGNATURE OF DECEASED Peter Blumen | | 94. SIGNATURE OF DECEASED Peter Blumen | | 95. SIGNATURE OF DECEASED Peter Blumen | |
| 96. SIGNATURE OF DECEASED Peter Blumen | | 97. SIGNATURE OF DECEASED Peter Blumen | | 98. SIGNATURE OF DECEASED Peter Blumen | | 99. SIGNATURE OF DECEASED Peter Blumen | | 100. SIGNATURE OF DECEASED Peter Blumen | |

BUREAU V. S.

RECEIVED

NOV 10 1952

10344

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10355
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

| | | | |
|--|---|--|---------------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Md.</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u> | LENGTH OF STAY (in this place) <u>2 days</u> | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cumberland</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u> | | STREET ADDRESS (If rural, give location) <u>419 Pine Place</u> | |
| 3. NAME OF DECEASED: (Type or Print) <u>Rosemary</u> | | 4. DATE OF DEATH <u>Nov. 18 19 55</u> | |
| (First) (Middle) (Last) | | | |
| <u>Miller</u> | | | |
| 5. SEX: <u>female</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u> | 8. DATE OF BIRTH: <u>Dec. 10-1952</u> |
| 9. AGE last birthday: <u>2</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Child</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: | |
| 11. BIRTHPLACE (State or foreign country): <u>Cumberland, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Louis W. Miller</u> | | 14. MOTHER'S MAIDEN NAME: <u>Hilda Rice</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>#no</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: <u>none</u> | |
| 17. INFORMANT & ADDRESS: <u>Memorial Hospital records</u> | | | |

| | | |
|--|---|--|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | |
| Immediate cause (a) <u>Shock, also 2nd. & 3rd. degree burns of body</u> | | <u>2 days</u> |
| Antecedent cause(s) (b) <u>from knees to hair line (front of body) arms</u> | | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>and hands.</u> | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |
| 19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>home</u>) | 21c. (City or town) (County) (State) <u>Cumberland Allegany 01 Md.</u> |
| 21d. TIME (Month) (Day) (Year) <u>Nov. 17/55 P. M.</u> | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>Clothes caught fire from a gas water heater in Bathroom.</u> |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | |
| SIGNATURE <u>H. V. Deming M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Nov. 18-1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | DATE THEREOF <u>Nov. 21, 1955</u> | NAME OF CEMETERY OR CREMATORY <u>Shannon Cemetery</u> |
| LOCATION City, town, or county (State) <u>Cumberland, Maryland</u> | 24. FUNERAL DIRECTOR <u>Walter R. Panty, M.D.</u> | ADDRESS <u>Louis Stein, Inc.</u> |
| DATE REC'D BY LOCAL REG. <u>Nov. 21, 1955</u> | REGISTRAR'S SIGNATURE | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

NOV 28 1955

RECEIVED

10345 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

| | | | | | | | |
|---|------------------------|--|--------------------------------|--|-----------------------------|---|-----------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE XXXXXMARYLAND | | COUNTY ALLEGANY | |
| CITY OR TOWN 02 CUMBERLAND, MD. | | LENGTH OF STAY 4 MINUTES | | CITY OR TOWN 02 CUMBERLAND | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES., | | | | STREET ADDRESS (If rural give location) 1 418 CENTRAL AVE., | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) ARZIE MOORE | | | | 4. DATE OF DEATH (Month) (Day) (Year) NOV. 16 1955 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED | 8. DATE OF BIRTH JULY 26, 1883 | 9. AGE last birthday 72 yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heater | | 10b. KIND OF BUSINESS OR INDUSTRY Tin Plate Mill | | 11. BIRTHPLACE (State or foreign country) W.VA. Daybrook | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME JOHN MOORE | | | | 14. MOTHER'S MAIDEN NAME SARAH JANE MARTIN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | | 16. SOCIAL SECURITY NO. 178-09-1143 | | 17. INFORMANT & ADDRESS Clay Moore, Elizabeth, Pa. | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 4-8 Hrs | |
| IMMEDIATE CAUSE (A) Myocarditis | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO | | | | | | 4-8 Hrs | |
| STATING UNDERLYING CAUSE LAST. (C) Venous pneumonia | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile arteriosclerosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Nov 14, 1955, to Nov 16, 1955, that I last saw the deceased alive on Nov 16, 1955, and that death occurred at 12:57 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE H. W. George | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 11/19/55 | | NAME OF CEMETERY OR CREMATORY Greene Co. Memorial Park | | LOCATION (City, town, or county) (State) Waynesburg, Penna. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE Wm. R. Frank M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George | | ADDRESS Cumberland, Md. | |

10845 CERTIFICATE OF DEATH

REQUISITI

10343 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY Allegany
CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN CumbarlandMARYLAND
LENGTH OF STAY
(in this place)
2 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN CumbarlandSTREET ADDRESS
(If rural give location)
505 Beall Street3. NAME OF DECEASED
(Type or Print)(First) Anno (Middle) (Last) Morris4. DATE OF DEATH (Month) (Day) (Year)
Nov. 1 19555. SEX
F6. COLOR OR RACE
W7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
W8. DATE OF BIRTH
October 3 18689. AGE last birthday
87 yrs.IF UNDER 1 YEAR
Months DaysIF UNDER 24 HRS.
Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife10b. KIND OF BUSINESS OR INDUSTRY
Own House11. BIRTHPLACE (State or foreign country)
Frostburg, Maryland12. CITIZEN OF WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

Perry Weimer

14. MOTHER'S MAIDEN NAME

Catherine Ziebaugh15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
No16. SOCIAL SECURITY NO.
None17. INFORMANT & ADDRESS
Earl Morris, Cumbarland, Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A)
ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)

18. MEDICAL CERTIFICATION

Pulmonary HypostasisCercbral HemorrhageGeneral ArteriosclerosisSenile Psychosis

INTERVAL BETWEEN ONSET AND DEATH

4 days10 days72 mo.

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)
M. ☐ Not while at work ☐21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 2, 1955 to Nov. 15, 1955, that I last saw the deceased alive on Oct. 3, 1955, and that death occurred at 11:40 M. from the causes and on the date stated above.

SIGNATURE

James E. McLean

M. D.

ADDRESS (Street, city, town, state)

19 Greene St

DATE SIGNED

11-1-5523. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

DATE THEREOF

Nov 3 1955

NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

LOCATION (City, town, or county)

Cumbarland, Md.

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

Nov. 3, 1955 Winter R. Frantz, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

William H. Kight, Cumbarland, Md.

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10358

10347

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> | | COUNTY <u>Alle gany</u> | | | |
| CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland,</u> | | LENGTH OF STAY (in this place) | | CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland,</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>910 Holland St.,</u> | | | | STREET ADDRESS (If rural give location) <u>1</u> <u>910 Holland St.,</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>FLORENCE</u> <u>REGINA</u> <u>MORRISSEY</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov.</u> <u>21,</u> <u>1955</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>June 30, 1906</u> | | 9. AGE last birthday <u>49</u> yrs. | IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.) | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Borden Shaft, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME <u>John A. Chapman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine E. Trapp</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No,</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>E. Leo Morrissey 910 Holland St.,</u> <u>Cumberland, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Carcinoma</u> <u>Cervix</u> | | | | | | <u>? years</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Uremia</u> | | | | | | <u>2 weeks</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>0</u> | | 19b. MAJOR FINDINGS OF OPERATION <u></u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u></u> | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u></u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u></u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u></u> | | | |
| 22. I hereby certify that I attended the deceased from <u>May 23, 1955</u> <u>11/20</u> , to <u>11/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/20</u> , 19 <u>55</u> , and that death occurred at <u>1:50 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>W R Hodges</u> | | M.D. <u>Cumberland, Md</u> | | DATE SIGNED <u>11/20/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>11/23/55</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cem.</u> | | LOCATION (City, town, or county) (State) <u>Frostburg, Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>November 22, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> <u>Cumberland, Md.</u> | | | |

10398

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

10398 CERTIFICATE OF DEATH

Reg. Cert. No.

1. REGISTRATION NUMBER OF DECEASED

2. NAME OF DECEASED

3. SEX AND AGE

4. PLACE OF BIRTH

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF COURT

20. SIGNATURE OF STATE

21. SIGNATURE OF COUNTY

22. SIGNATURE OF CITY

23. SIGNATURE OF TOWN

24. SIGNATURE OF VILLAGE

25. SIGNATURE OF PARISH

26. SIGNATURE OF CHURCH

27. SIGNATURE OF SYNAGOGUE

28. SIGNATURE OF MOSQUE

29. SIGNATURE OF TEMPLE

30. SIGNATURE OF MONASTERY

31. SIGNATURE OF CONVENT

32. SIGNATURE OF NUNNERY

33. SIGNATURE OF PRIORY

34. SIGNATURE OF ABBEY

35. SIGNATURE OF BISHOPRIC

36. SIGNATURE OF ARCHBISHOPRIC

37. SIGNATURE OF DIOCESE

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39. SIGNATURE OF CHURCH

40. SIGNATURE OF SYNAGOGUE

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42. SIGNATURE OF TEMPLE

43. SIGNATURE OF MONASTERY

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273. SIGNATURE OF CHURCH

274. SIGNATURE OF SYNAGOGUE

275. SIGNATURE OF MOSQUE

10348

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>023 TOWN Cumberland</u> | | LENGTH OF STAY (In this place) <u>26 years</u> | | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Eckhart</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>(Sylvan Retreat)</u> | | | | STREET ADDRESS (If rural, give location) <u>/</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) <u>Thomas Greenly Phillips</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 28 19 55</u> | | | |
| 5. SEX: <u>male</u> | | 6. COLOR OR RACE: <u>white</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u> | | 8. DATE OF BIRTH: <u>Nov. 2-1897</u> | |
| 9. AGE last birthday: <u>58</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of work life, if retired) <u>Laborer Patient at Sylvan Retreat.</u> | | 11. BIRTHPLACE (State or foreign country): <u>Eckhart, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Thomas G. Phillips</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Catherine Isabelle Nelson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY No.: <u>none</u> | | 17. INFORMANT & ADDRESS: <u>(sister) Leona Phillips, Eckhart, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | sudden |
| <u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>Coronary sclerosis.</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) | | | | | | | ? |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: <u>0</u> | | | | 19b. MAJOR FINDING OF OPERATION: | | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>H.V. Deming M.D.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>Nov. 28-1955</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF <u>Nov. 30, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Brothing Memorial Park, Brothing, Maryland</u> | | LOCATION (City, town, or county) (State) <u>Brothing, Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>Nov. 29, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u> | | 24. FUNERAL DIRECTOR <u>Walter R. Frank, M.D.</u> | | ADDRESS <u>Walter R. Frank, M.D.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 30 1955

BUREAU V. 3

10360

10349 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Cumberland</u> | | | | TOWN <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>516 Woodside Avenue</u> | | | | STREET ADDRESS (If rural give location) <u>516 Woodside Avenue</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| JOHN RAE | | | | November 28 19 55 | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | | 8. DATE OF BIRTH <u>July 2, 1883</u> | |
| 9. AGE last birthday <u>72</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Stonemason</u> | | 11. BIRTHPLACE (State or foreign country) <u>Scotland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Rae</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth McGee</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>220-10-2114</u> | | 17. INFORMANT & ADDRESS <u>Mrs. John Rae, Cumberland, Maryland</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>420.9 congestive heart failure</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic heart disease</u> | | | | | | <u>1 year</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>none</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>8</u> | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 11-27-55, to 11-28-55, that I last saw the deceased alive on 11-27-55, and that death occurred at 5:00 P.M. from the causes and on the date stated above. SIGNATURE <u>L. R. H. M.D.</u> ADDRESS (Street, city, town, state) <u>57 Green St. Cumberland, Md.</u> DATE SIGNED <u>11-30-55</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Dec. 1, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cem</u> | | LOCATION (City, town, or county) (State) <u>Frostburg, Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>Dec. 1, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u> | | ADDRESS <u>Cumberland, Maryland</u> | |

5:00 P.M. - Forwarded to Balto. Dec. 2, 1955

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

10909

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Dec. 1914

1. DECEASED PERSON'S NAME OR DESIGNATION

2. SEX

3. AGE

4. OCCUPATION

5. CITY

6. STATE

7. COUNTY

8. DATE OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. CAUSE OF DEATH

12. MANNER OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF MINISTER

17. SIGNATURE OF JUDGE

18. SIGNATURE OF CLERK

19. SIGNATURE OF DECEASED

20. SIGNATURE OF WITNESSES

21. SIGNATURE OF PHYSICIAN

22. SIGNATURE OF MINISTER

23. SIGNATURE OF JUDGE

24. SIGNATURE OF CLERK

25. SIGNATURE OF DECEASED

26. SIGNATURE OF WITNESSES

27. SIGNATURE OF PHYSICIAN

28. SIGNATURE OF MINISTER

29. SIGNATURE OF JUDGE

30. SIGNATURE OF CLERK

31. SIGNATURE OF DECEASED

32. SIGNATURE OF WITNESSES

33. SIGNATURE OF PHYSICIAN

34. SIGNATURE OF MINISTER

35. SIGNATURE OF JUDGE

36. SIGNATURE OF CLERK

37. SIGNATURE OF DECEASED

38. SIGNATURE OF WITNESSES

39. SIGNATURE OF PHYSICIAN

40. SIGNATURE OF MINISTER

BUREAU V. 2

DEC 8 1914

RECEIVED

INSTRUCTIONS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Within corporate limits

10350

CERTIFICATE OF DEATH

10361

Reg. Dist. No. 4

| | | | | | | | |
|--|-------------------------|---|-------------------------|--|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ALLEGANY</u> | | STATE <u>MARYLAND</u> | | COUNTY <u>ALLEGANY</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>CUMBERLAND</u> | | <u>9 DAYS</u> | | TOWN <u>OLDTOWN</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u> | | | | STREET ADDRESS (If rural give location) | | | |
| <u>60 MEMORIAL & WARWICK AVES.</u> | | | | <u>1</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>SUSAN J. REESER</u> | | | | <u>NOV. 14 19 55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>FEMALE</u> | <u>WHITE</u> | <u>WIDOWED</u> | <u>SEPT. 27, 1871</u> | <u>84</u> | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | <u>MARYLAND</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>ELEX HOWELL</u> | | | | <u>HARRIET SNYDER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>None</u> | | <u>None</u> | | <u>MEMORIAL HOSPITAL, CUMBERLAND, MD.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>331X</u> | | | | <u>Massive Cerebral Hemorrhage</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Right Hemiplegia</u> | | | | <u>Nov. 5, 1955</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Stroke</u> | | | | <u>9 days</u> | | | |
| | | | | <u>5 days</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov. 5, 1955</u> , to <u>Nov. 14, 1955</u> , that I last saw the deceased alive on <u>Nov. 14, 1955</u> , and that death occurred at <u>7:55A</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Clayton J. Jurett</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Cumberland, Md</u> | | DATE SIGNED <u>11/14/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>11/16/55</u> | | <u>Mt Olivet Cemetery</u> | | <u>Near Oldtown Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>11-15-55</u> | | <u>Walter R. Jurett, M.D.</u> | | <u>Louis Allen Inc.</u> | | <u>Cumberland, Md</u> | |

1992

HOFER, J.

YH-03-15

2547

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10362

Within corporate limits 10351

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|----------------------------------|--|--|--|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | | | |
| CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland</u> | | LENGTH OF STAY (In this place) | | CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>531 Washington St.</u> | | | | STREET ADDRESS (If rural give location) <u>531 Washington St.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>WILLIS M. RICKEY</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 14</u> <u>19 55</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Oct. 12, 1869</u> | 9. AGE last birthday <u>86</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired dispatcher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. RR</u> | | 11. BIRTHPLACE (State or foreign country) <u>Cameron, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>John W. Rickey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Clara B. Williams</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>705-05-8140</u> | | 17. INFORMANT & ADDRESS <u>Mrs. Wylie Fay, 531 Washington St.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Coronary arterial occlusion</u> | | | | | | <u>36 hours</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio sclerotic vascular disease</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes Mellitus</u> | | | | | | <u>8 years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>None</u> | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>46</u> , to <u>Nov. 14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 14</u> , 19 <u>55</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Wylie Fay Jr.</u> | | | | ADDRESS (Street, city, town, state) <u>5 Washington St. Cumberland</u> | | DATE SIGNED <u>Nov 15</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Nov. 16, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| 24. REC'D BY REGISTRAR DATE <u>11-16-55</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Drantz M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George,</u> | | ADDRESS <u>Cumberland, Md.</u> | |

10363

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

Reg. Dist. No.

1. LOCAL RESIDENCE (House or Detached)

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERGYMAN

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF WATER

27. SIGNATURE OF FIRE

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF REBIRTH

34. SIGNATURE OF RESURRECTION

35. SIGNATURE OF JUDGMENT

36. SIGNATURE OF GLORY

37. SIGNATURE OF HONOR

38. SIGNATURE OF POWER

39. SIGNATURE OF WEALTH

40. SIGNATURE OF KNOWLEDGE

41. SIGNATURE OF WISDOM

42. SIGNATURE OF FAITH

43. SIGNATURE OF HOPE

44. SIGNATURE OF CHARITY

BUREAU V. 3

10/17 1955

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10352

10352

CERTIFICATE OF DEATH

DR. R.J. WILLIAMS

Reg. Dist. No. 4

| | | | | | | | |
|---|---|---|--|--|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | STATE MARYLAND | | COUNTY ALLEGANY | | | |
| CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND | | LENGTH OF STAY (in this place) 15 DAYS | | CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near CUMBERLAND, rural | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL | | STREET ADDRESS ROUTE #3, Bedford Road | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) JOHN (Middle) R. (Last) RODECAP | | | | (Month) NOVEMBER (Day) 22 (Year) 19 55 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH 12-20-1882 | | 9. AGE last birthday 72 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY Celomese Corp | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME SUSAN RODECAP | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | | 16. SOCIAL SECURITY NO. 2 17-10-6156 | | 17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 420.1 IMMEDIATE CAUSE (A) Coronary Thrombosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 days | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Nephritis & Uremia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 11/7/55, 19 to 11/22/55, 19, that I last saw the deceased alive on 11/22/55, 19, and that death occurred at 10:42 P.M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>R. J. Williams</i> | | DATE THEREOF Nov 26 1955 | | NAME OF CEMETERY OR CREMATORY Zion Memorial Burial Park | | LOCATION (City, town, or county) Cumberland Md. | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 1 | | 24. REC'D BY REGISTRAR | | 25. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md. | | DATE SIGNED 11/23/55 | |

10352

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

10352 CERTIFICATE OF DEATH

DR. R. L. WILLIAMS

ALLIANCE

WASHINGT

GENERAL HOSPITAL

JOHN

12-20-1935

WHITE

12-20-1935

RETIRED

VIRGINIA

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GENERAL HOSPITAL - CUMMINGS, MD.

BUREAU V. S.

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10353

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|------------------|--|------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE MARYLAND | | COUNTY ALLEGANY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 41 DAYS | | TOWN FLINTSTONE | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| MEMORIAL HOSPITAL MEMORIAL AVE. | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) (Middle) (Last) | | | | (Month) (Day) (Year) | | | |
| MRS. PEARL L. Leona RUBLE | | | | NOV. 23 19 55 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| FEMALE | WHITE | MARRIED | MAY 25, 1902 | 53 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | Own home | | PENNA., Hammondville | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| JAMES WASHBAUGH | | | | BLANCHE RICHARDS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| N O | | None | | MEMORIAL HOSPITAL. CUMBERLAND, MD. | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 18a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 170x IMMEDIATE CAUSE (A) metastatic Carcinoma | | | | | | 1 yr. | |
| ANTECEDENT CAUSE(S) DUE TO Carcinoma, Rt breast | | | | | | 2 1/2 yr. | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| 18b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? | |
| 1954 | | Carcinoma (adeno-) Rt breast | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | M. | | | | | |
| 22. I hereby certify that I attended the deceased from May, 19 48, to May, 19 55, that I last saw the deceased alive on May, 19 55, and that death occurred at 3:10 PM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| C. J. Haffer | | | | Cumberland Md 11/25/55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial 1 | | 11/26/55 | | Hillcrest | | Cumberland, Maryland | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| Nov. 26, 1955 | | Walter R. Frank, M.D. | | John J. Haffer, Cumberland, Md. | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

2017-08-14 14:14:14

1 With corporate limit:

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10354

CERTIFICATE OF DEATH

10366

Reg. Dist. No.

| | | | | | | | |
|--|------------------|--|-----------------------------------|---|---|---|------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE WEST VIRGINIA | | COUNTY MINERAL | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 11 DAYS | | TOWN PIEDMONT | | 85X-3 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 60 MEMORIAL HOSPITAL | | | | 18 E. HAMPSHIRE | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) ANNA | | (Middle) LEE | | (Last) SMITH | | (Month) 11 (Day) 25 (Year) 1955 | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| FEMALE | WHITE | MARRIED | JUNE 24, 1922 | 33 | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Housewife | | | Own Home | | SCHERR, W.VA. | | U.S.A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| LARRY HASLACKER | | | | ZETTIE BIBLE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | | | MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 757.1 IMMEDIATE CAUSE (A) | | | | | | Uremia | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | 1 mo | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | Polycystic Disease Kidneys | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | 33 yrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | M. | | | | | |
| 22. I hereby certify that I attended the deceased from Jan 1950, to 25 Nov 55, that I last saw the deceased alive on 25 Nov, 1955, and that death occurred at 3:13 AM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| Thrush B. Whitworth M.D. | | | | 25 Nov 55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| Burial | | Nov. 27, 1955 | | Maysville Cemetery | | Maysville, West Virginia | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE Nov. 25, 1955 | | Arthur R. Granty | | Thrush Funeral Home, Petersburg, W. Va. | | | |

10388

CERTIFICATE OF DEATH

Page One

| | | | |
|---------------------------------------|--|--|--|
| NAME OF DECEASED JAMES H. HARRIS | | DATE OF BIRTH 11/11/1911 | PLACE OF BIRTH BALTIMORE, MD |
| DATE OF DEATH 11/11/1955 | | PLACE OF DEATH BALTIMORE, MD | CAUSE OF DEATH HEART DISEASE |
| MANNER OF DEATH NATURAL | | PERIOD OF ILLNESS 10 DAYS | DATE OF BURIAL 11/12/1955 |
| NAME OF PHYSICIAN DR. J. H. HARRIS | | NAME OF HOSPITAL BALTIMORE HOSPITAL | NAME OF FUNERAL HOME BALTIMORE FUNERAL HOME |

| | | | |
|---------------------------------|---------------------------|----------------------------|-------------------------------|
| SEX MALE | AGE 44 | EDUCATION HIGH SCHOOL | OCCUPATION LABORER |
| RELIGION METHODIST | ETHNIC ORIGIN WHITE | DATE OF MARRIAGE 1935 | NAME OF SPOUSE JANE HARRIS |
| DATE OF LAST ILLNESS 11/1/55 | DATE OF DEATH 11/11/55 | DATE OF BURIAL 11/12/55 | DATE OF INTERMENT 11/12/55 |

| | | |
|---|---------------------------------------|--|
| NAME OF HOSPITAL BALTIMORE HOSPITAL | NAME OF PHYSICIAN DR. J. H. HARRIS | NAME OF FUNERAL HOME BALTIMORE FUNERAL HOME |
| NAME OF INTERMENT PLACE BALTIMORE CEMETERY | NAME OF MINISTER REV. J. H. HARRIS | NAME OF BURIAL PLACE BALTIMORE CEMETERY |

| | | |
|-------------------------------------|---------------------------------|---------------------------------|
| NAME OF DECEASED JAMES H. HARRIS | DATE OF BIRTH 11/11/1911 | PLACE OF BIRTH BALTIMORE, MD |
| DATE OF DEATH 11/11/1955 | PLACE OF DEATH BALTIMORE, MD | CAUSE OF DEATH HEART DISEASE |

| | | |
|---|--|--|
| NAME OF PHYSICIAN DR. J. H. HARRIS | NAME OF HOSPITAL BALTIMORE HOSPITAL | NAME OF FUNERAL HOME BALTIMORE FUNERAL HOME |
| NAME OF INTERMENT PLACE BALTIMORE CEMETERY | NAME OF MINISTER REV. J. H. HARRIS | NAME OF BURIAL PLACE BALTIMORE CEMETERY |

| | | |
|-------------------------------------|---------------------------------|---------------------------------|
| NAME OF DECEASED JAMES H. HARRIS | DATE OF BIRTH 11/11/1911 | PLACE OF BIRTH BALTIMORE, MD |
| DATE OF DEATH 11/11/1955 | PLACE OF DEATH BALTIMORE, MD | CAUSE OF DEATH HEART DISEASE |

BUREAU V. S.

NOV 28 1955

RECEIVED

21010001211

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 10b Film 189 11-16-55 et

10367

10355
Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|---|---|--|--|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland,</u> | | LENGTH OF STAY (in this place) <u>6 Days</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital Memorial Ave.</u> | | | | STREET ADDRESS (If rural give location) <u>209 Bedford St.</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>Mr. Benjamin W. Smith</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 6 19 55</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Oct. 22 27, 1906</u> | 9. AGE last birthday <u>49</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Odd Jobs</u> | | 11. BIRTHPLACE (State or foreign country) <u>Harrisonburg, W.Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Gideon Smith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Armanda Crider</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Y</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Memorial Hospital, Cumberland, Md.</u> | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 422.2 IMMEDIATE CAUSE (A) <u>Uraemia</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocarditis</u> | | | | | | <u>2 wks</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Secondary Anaemia</u> | | | | | | <u>6 mon</u> | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>0</u> | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov 1</u> 19 <u>55</u> to <u>Nov 6</u> 19 <u>55</u>, that I last saw the deceased alive on <u>Nov 6</u> 19 <u>55</u>, and that death occurred at <u>6:45 PM</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Clayton L. Fennell</u> | | | | ADDRESS (Street, city, town, state) <u>Cumberland</u> | | DATE SIGNED <u>11/7/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Nov. 9, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor Meth. Cem.</u> | | LOCATION (City, town, or county) (State) <u>Allegany County, Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>11-9-55</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Drantz, MHA</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer,</u> | | ADDRESS <u>Cumberland, Maryland</u> | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY | Allegany | STATE | Md. COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | Cumberland | CITY (If outside corporate limits write RURAL and give nearest town) | Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | Dead on arrival at the Sacred Heart Hospital. | STREET ADDRESS | 113 N.Center St. |
| 3. NAME OF DECEASED: | (First) Daisy | (Middle) D. | (Last) Smith |
| 4. DATE OF DEATH | Nov. | 22 | 19 55 |
| 5. SEX: | female | 6. COLOR OR RACE: | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | widow | 8. DATE OF BIRTH: | Nov. 21-1873 |
| 9. AGE last birthday: | 82 | 10. USUAL OCCUPATION (Give kind of work done during most of work life, or if retired): | for-Dutchmaid-Zanol Products, Claibourne, Ohio. |
| 11. BIRTHPLACE (State or foreign country): | U.S.A. | 12. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 13. FATHER'S NAME: | James Thatcher | 14. MOTHER'S MAIDEN NAME: | Caroline Osborne |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | no | 16. SOCIAL SECURITY No.: | 220-30-8274 |
| 17. INFORMANT & ADDRESS: | Cumberland, Md. James H. Littlefield, 434 N.Center St. | | |

| | | |
|---|--|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) Cardiac tamponade Antecedent cause(s) (b) dissecting aneurism Diseases or conditions, if any, giving rise to the above cause (c) cardiac rupture. stating underlying cause last | | sudden |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |
| 19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) (County) (State) |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M.D. CHIEF MEDICAL EXAMINER * DEPUTY MEDICAL EXAMINER * ASSISTANT MEDICAL EXAM. * Nov. 23-1955 | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY |
| Burial | Nov. 25, 1955 | Rose Hill Cemetery, Cumberland, Maryland |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
| Nov. 25, 1955 | Walter K. Frank, M.D. | Louis Stern, Inc. |

MARGIN RESERVED FOR BINDING

RECEIVED

NOV 28 1955

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10389

No. 4

| | | | |
|--|---|--|---------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY | Allegany | STATE | Md. COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | Cumberland | CITY (If outside corporate limits write RURAL and give nearest town) | Flintstone |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | Dead on arrival at the Sacred Heart Hospital. | STREET ADDRESS | (If rural, give location) |
| 3. NAME OF DECEASED: | (First) Webster | (Middle) Mason | (Last) Smith |
| 4. DATE OF DEATH | Nov. 30 | 19 | 55 |
| 5. SEX: | Male | 6. COLOR OR RACE: | White |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | Married | 8. DATE OF BIRTH: | April 10-1892 |
| 9. AGE last birthday: | 63 | 10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): | Laborer |
| 11. BIRTHPLACE (State or foreign country): | Bedford Co. Pa. | 12. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 13. FATHER'S NAME: | Morgan Smith | 14. MOTHER'S MAIDEN NAME: | Martha Cavender |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | No | 16. SOCIAL SECURITY No.: | 204-03-5701 |
| 17. INFORMANT & ADDRESS: | (wife) Edna Powers Smith, Flintstone, Md. | | |

| | | |
|--|--|--|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | sudden |
| (a) Immediate cause | | |
| (b) Antecedent cause(s) | | |
| (c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | | 1 month |
| (d) (a) Coronary occlusion | | nearly all |
| (b) Coronary sclerosis | | his life. |
| (c) Bronchial asthma | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |
| 19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) (County) (State) |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | |
| SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED |
| H. V. Deming M.D. | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |
| H. V. Deming M.D. | | ASSISTANT MEDICAL EXAM. <input type="checkbox"/> |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | DATE THEREOF | LOCATION (City, town, or county) (State) |
| Burial | Dec. 3, 1955 | Artemas, Pennsylvania |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
| Dec. 1, 1955 | Walter R. Grant, M.D. | John J. Hoyer, Cumberland, Maryland |

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JEC 5 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate assembly should be detached for use as a burial transit permit.

MS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10370

10367 CERTIFICATE OF DEATH

Reg. Dist. No. 6

| | | | | | | | |
|--|-------------------------------|--|---------------------------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>43 Westernport</u> | | | | TOWN <u>43 Westernport</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>223 Poplar ST</u> | | | | STREET ADDRESS (If rural give location) <u>223 Poplar ST</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>MALISSA Christina Stuby</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 12 1955</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u> | 8. DATE OF BIRTH <u>21 April 1868</u> | 9. AGE last birthday <u>87</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Bedford County, Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Martin A. Miller</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Smith</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Charles Stuby, Lonaconing, Md</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>420.1 Coronary Occlusion</u> | | | | | | <u>3hrs</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio sclerosis.</u> | | | | | | <u>5yrs</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized Arthritis</u> | | | | | | <u>2yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>0</u> | | 19b. MAJOR FINDINGS OF OPERATION | | 2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White et work <input type="checkbox"/> Not white et work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov 12, 1955</u> , to <u>Nov 12, 1955</u> , that I last saw the deceased alive on <u>Nov 12, 1955</u> , and that death occurred at <u>1:15M</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>James A. Kelly M.D.</u> | | | | ADDRESS (Street, city, town, state) <u>Piedmont W Va</u> | | DATE SIGNED <u>Nov 14 55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>11-14-55</u> | | NAME OF CEMETERY OR CREMATORY <u>Philbs Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Westernport Md.</u> | |
| 24. REC'D BY REGISTRAR <u>DATE 11-14-55</u> | | REGISTRAR'S SIGNATURE <u>Mrs. Jon C. Kelly</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Bral</u> | | ADDRESS <u>Westernport Md.</u> | |

[illegible]

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10358 CERTIFICATE OF DEATH

10371

Reg. Dist. No. 4.

| | | | | | | | |
|--|------------------|--|-----------------------------------|---|---|--|------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Allegany | | MARYLAND | | STATE Maryland | | COUNTY Allegany | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN Cumberland | | 11/8/55 | | TOWN Cumberland | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary | | | | STREET ADDRESS (If rural give location) 142 Bedford Street | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) Alice (Middle) May (Last) Tomlinson | | | | (Month) November (Day) 28 (Year) 1955 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Female | White | Widow | 9/21/1872 | 83 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Housewife & former teacher | | | | | Mt. Savage, Maryland | | U. S. A. |
| 13. FATHER'S NAME Israel Jukes | | | | 14. MOTHER'S MAIDEN NAME Mary Timmons | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | None | | Allegany County Infirmary Records | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) Chronic Myocardial Degeneration | | | | INTERVAL BETWEEN ONSET AND DEATH ? | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Coronary Arteriosclerosis | | | | ? | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Pericarditis | | | | ? | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Nephritis | | | | ? | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from Nov. 8, 1955 , to Nov. 28, 1955 , that I last saw the deceased alive on Nov. 27, 1955 , and that death occurred at 4 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE James H. Lean | | | | ADDRESS (Street, city, town, state) 49 Greene St. | | DATE SIGNED 11-28-55 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF Nov 30 1955 | | NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | LOCATION (City, town, or county) Cumberland Md. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE Walter R. Frantz, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md. | | ADDRESS | |

10331

U.S. DEPARTMENT OF HEALTH - WASHINGTON, D.C.

1955 CERTIFICATE OF DEATH

Date of Death

Place of Death

Name of Deceased

Sex

Age

Cause of Death

Manner of Death

Place of Death

Date of Death

Cause of Death

Manner of Death

Place of Death

Sex

Age

Date of Death

Cause of Death

Manner of Death

Place of Death

Name of Deceased

Sex

Age

Date of Death

Cause of Death

Manner of Death

Place of Death

Date of Death

Cause of Death

Manner of Death

Place of Death

Date of Death

Cause of Death

Manner of Death

Place of Death

BUREAU V. 3

OCT 30 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10378 CERTIFICATE OF DEATH

10372

Reg. Dist. No. 6

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| OR TOWN <u>Westernport-rural</u> | | LENGTH OF STAY (in this place) <u>58 yrs</u> | | OR TOWN <u>Westernport rural</u> | | OR TOWN <u>Westernport rural</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RED # 1, Box 123</u> | | STREET ADDRESS (If rural give location) <u>RED # 1, Box 123</u> | | | | | |
| 3. NAME OF DECEASED (Type or Print) <u>ETHEL CORA TRAVIS</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 19 19 55</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | | 8. DATE OF BIRTH <u>18 Jan 1897</u> | |
| 9. AGE last birthday <u>58</u> yrs. | | 10. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Westernport, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | | |
| 13. FATHER'S NAME <u>Gibson Ravenscroft</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Cora Ward</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT & ADDRESS <u>John B. Travis, Westernport, Mar</u> | | | | 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 420.1 IMMEDIATE CAUSE (A) <u>Hypertension Cardio-Vascular</u> | | | | 20 yrs | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>renal disease</u> | | | | 6 mo | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Coronary Thrombosis</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>0</u> | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov 19, 19 55</u> , to <u>Nov 19, 19 55</u> , that I last saw the deceased alive on <u>Nov 19, 19 55</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>P. E. Berry</u> | | M.D. <u>Ashfield St. Richmond Wb</u> | | ADDRESS (Street, city, town, state) | | DATE SIGNED <u>11-21-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>11-22-55</u> | | NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Westernport, Md.</u> | |
| 24. REC'D BY REGISTRAR <u>11-22-55</u> | | REGISTRAR'S SIGNATURE <u>Mrs. Jean C. Kelly</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Boal</u> | | ADDRESS <u>Westernport, Md.</u> | |

10375

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF CLERK

21. SIGNATURE OF ASSISTANT CLERK

22. SIGNATURE OF RECEPTIONIST

23. SIGNATURE OF TELEPHONE OPERATOR

24. SIGNATURE OF MAIL ROOM

25. SIGNATURE OF RECORDS SECTION

26. SIGNATURE OF STATISTICS SECTION

27. SIGNATURE OF LABORATORY

28. SIGNATURE OF X-RAY DEPARTMENT

29. SIGNATURE OF RADIOLOGY DEPARTMENT

30. SIGNATURE OF PATHOLOGY DEPARTMENT

31. SIGNATURE OF BACTERIOLOGY DEPARTMENT

32. SIGNATURE OF VIROLOGY DEPARTMENT

33. SIGNATURE OF IMMUNOLOGY DEPARTMENT

34. SIGNATURE OF EPIDEMIOLOGY DEPARTMENT

35. SIGNATURE OF PUBLIC HEALTH DEPARTMENT

36. SIGNATURE OF HEALTH EDUCATION DEPARTMENT

37. SIGNATURE OF COMMUNITY HEALTH DEPARTMENT

38. SIGNATURE OF SCHOOL HEALTH DEPARTMENT

39. SIGNATURE OF OCCUPATIONAL HEALTH DEPARTMENT

40. SIGNATURE OF INDUSTRIAL HEALTH DEPARTMENT

41. SIGNATURE OF AGRICULTURAL HEALTH DEPARTMENT

42. SIGNATURE OF MARINE HEALTH DEPARTMENT

43. SIGNATURE OF AIR FORCE HEALTH DEPARTMENT

44. SIGNATURE OF NAVY HEALTH DEPARTMENT

45. SIGNATURE OF COAST GUARD HEALTH DEPARTMENT

46. SIGNATURE OF CUSTOMS HEALTH DEPARTMENT

47. SIGNATURE OF EXERCISES DEPARTMENT

48. SIGNATURE OF RECREATION DEPARTMENT

49. SIGNATURE OF ARTS DEPARTMENT

50. SIGNATURE OF SCIENCES DEPARTMENT

51. SIGNATURE OF LETTERS DEPARTMENT

52. SIGNATURE OF BOOKS DEPARTMENT

53. SIGNATURE OF MUSIC DEPARTMENT

54. SIGNATURE OF THEATRE DEPARTMENT

55. SIGNATURE OF CINEMA DEPARTMENT

56. SIGNATURE OF RADIO DEPARTMENT

57. SIGNATURE OF TELEVISION DEPARTMENT

58. SIGNATURE OF COMMERCE DEPARTMENT

59. SIGNATURE OF INDUSTRY DEPARTMENT

60. SIGNATURE OF TRANSPORT DEPARTMENT

61. SIGNATURE OF COMMUNICATIONS DEPARTMENT

62. SIGNATURE OF INFORMATION DEPARTMENT

63. SIGNATURE OF RESEARCH DEPARTMENT

64. SIGNATURE OF DEVELOPMENT DEPARTMENT

65. SIGNATURE OF EVALUATION DEPARTMENT

66. SIGNATURE OF MONITORING DEPARTMENT

67. SIGNATURE OF ASSESSMENT DEPARTMENT

68. SIGNATURE OF IMPROVEMENT DEPARTMENT

69. SIGNATURE OF INNOVATION DEPARTMENT

70. SIGNATURE OF ADAPTATION DEPARTMENT

71. SIGNATURE OF ACQUISITION DEPARTMENT

72. SIGNATURE OF STABILIZATION DEPARTMENT

73. SIGNATURE OF PROTECTION DEPARTMENT

74. SIGNATURE OF DEFENSE DEPARTMENT

75. SIGNATURE OF OFFENSE DEPARTMENT

76. SIGNATURE OF REPAIR DEPARTMENT

77. SIGNATURE OF MAINTENANCE DEPARTMENT

78. SIGNATURE OF CONSTRUCTION DEPARTMENT

79. SIGNATURE OF EXCAVATION DEPARTMENT

80. SIGNATURE OF FOUNDATION DEPARTMENT

81. SIGNATURE OF ROOFING DEPARTMENT

82. SIGNATURE OF SIDERING DEPARTMENT

83. SIGNATURE OF GLAZING DEPARTMENT

84. SIGNATURE OF PAINTING DEPARTMENT

85. SIGNATURE OF CARPENTRY DEPARTMENT

86. SIGNATURE OF JOINERY DEPARTMENT

87. SIGNATURE OF MILLWRIGHT DEPARTMENT

88. SIGNATURE OF BLACKSMITH DEPARTMENT

89. SIGNATURE OF WELDER DEPARTMENT

90. SIGNATURE OF FOUNDRY DEPARTMENT

91. SIGNATURE OF MACHINE SHOP DEPARTMENT

92. SIGNATURE OF TOOL AND DIE DEPARTMENT

93. SIGNATURE OF DIE CASTING DEPARTMENT

94. SIGNATURE OF FORTHRIGHT DEPARTMENT

95. SIGNATURE OF FORTHRIGHT DEPARTMENT

96. SIGNATURE OF FORTHRIGHT DEPARTMENT

97. SIGNATURE OF FORTHRIGHT DEPARTMENT

98. SIGNATURE OF FORTHRIGHT DEPARTMENT

99. SIGNATURE OF FORTHRIGHT DEPARTMENT

100. SIGNATURE OF FORTHRIGHT DEPARTMENT

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10373

10368 CERTIFICATE OF DEATH

Reg. Dist. No. 9

| | | | | | | | |
|---|------------------|--|-----------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>MARYLAND</u> | | STATE <u>W. Va.</u> | | COUNTY <u>Hampshire</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Frostburg,</u> | | <u>5 days</u> | | TOWN <u>Springfield</u> | | <u>85 X-3</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>61 Miner's Hospital</u> | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Maurice</u> (Middle) <u>Warnick</u> (Last) | | | | (Month) <u>Nov</u> (Day) <u>26</u> (Year) <u>1958</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>Single</u> | <u>June 8th, 1877</u> | <u>78</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Ret. Miner</u> | | <u>Coal Mining</u> | | <u>Maryland</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Asa Warnick</u> | | | | <u>Alice McGruder</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>Unk.</u> | | <u>213-09-6593</u> | | <u>Harry Keedy, Ormond St., Frostburg,</u> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>Chr Nephritis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr Myocardial Insufficiency</u> | | | | <u>" "</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov 22, 1955</u> , to <u>Nov 26, 1955</u> , that I last saw the deceased alive on <u>Nov 26, 1955</u> , and that death occurred at <u>2:03 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Wm C Lane MD</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Frostburg Md</u> | | DATE SIGNED <u>Nov 28 1955</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>11-29-55</u> | | <u>Laurel Hill C metary</u> | | <u>Moscow, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>11-29-55</u> | | <u>Mr. Nancy N. Roe</u> | | <u>Joseph R. Durst,</u> | | <u>Frostburg, Md.</u> | |

10073

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1955 CERTIFICATE OF DEATH

Form 1007-10-55

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. MANNER OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESS

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF CLERGY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF COUNTY CLERK

BUREAU V. S.

DEC 5 1955

RECEIVED

1
WITHIN CORPORATE LIMITS

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10374

10359
DR. W.F. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|---|--------------------------------|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY ALLEGANY | MARYLAND | STATE WEST VIRGINIA | COUNTY GRANT |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| TOWN CUMBERLAND | 7 DAYS | TOWN PETERSBURG | 85X.3 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| 60 MEMORIAL HOSPITAL | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | 4. DATE OF DEATH (Month) (Day) (Year) | |
| RALPH PARKER WELTON | | NOVEMBER 26 19 55 | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH |
| MALE | WHITE | MARRIED | APRIL 9, 1909 |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE last birthday yrs. |
| PUBLISHER & EDITOR | | NEWSPAPER | 46 |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| WEST VIRGINIA | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| ARCH J. WELTON | | CORA PARKER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| No | | | |
| 17. INFORMANT & ADDRESS | | MEMORIAL HOSPITAL - CUMBERLAND, MD. | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| 420.1 IMMEDIATE CAUSE (A) | | Coronary Thrombosis | |
| ANTECEDENT CAUSE(S) DUE TO | | Coronary Arteriosclerosis | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | First attack Sept '53 | |
| 19e. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| | | | |
| 21f. HOW DID INJURY OCCUR? | | | |
| | | | |
| 22. I hereby certify that I attended the deceased from 12-27-53 to 11-26-55, that I last saw the deceased alive on 12-26-55, and that death occurred at 10:42 A.M. from the causes and on the date stated above. | | | |
| SIGNATURE | | ADDRESS (Street, city, town, state) | |
| W. F. Williams M.D. Cumberland Md. | | 11-26-55 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| Buried. | Nov. 29, 1955. | Maple Hill Cemetery. | Petersburg, W. Va. |
| 24. REC'D BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | |
| Nov. 28, 1955 | Walter R. Zantz, M.D. | J. Blaine Schaeffer Petersburg, W. Va. | |

BUREAU V. S.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10360
Within corporate limits
Item 14, Film 189 11-16-55 et

CERTIFICATE OF DEATH

10375

Reg. Dist. No. 4

| | | | | | | | |
|--|------------------|---|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE MARYLAND | | COUNTY ALLEGANY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR TOWN CUMBERLAND | |
| 02 TOWN CUMBERLAND | | 4 HRS. 15 MIN. | | STREET ADDRESS | | (If rural give location) | |
| 60 HOSPITAL OR INSTITUTION OR STREET ADDRESS | | MEMORIAL HOSPITAL | | 119 MASSACHUSETTS AVENUE | | 02 | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| JOSEPH M. WHETZEL | | | | NOV. 4 19 55 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| MALE | WHITE | MARRIED | JUNE 20, 1876 | 79 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Retired Tin plate Mill | | | | WEST VIRGINIA Hardy Co. | | U. S. A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| SAMFORD WHETZEL | | | | Ferne Rohrbough | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | 214-05-9020 | | MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 48 hrs - | |
| 420.1 IMMEDIATE CAUSE (A) Coronary Artery Disease | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from 11/2/55, 19....., to 11/4/55, 19....., that I last saw the deceased alive on 11/4/55, 19....., and that death occurred at 2:45 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | | |
| J. Williams | | | | Cumberland | | | |
| M.D. | | | | DATE SIGNED 11/5/55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 11-7-55 | | Cedarhill Cem. | | Near Mathias, W. Va. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | | |
| DATE Nov. 7, 1955 | | Walter R. Grant M.D. | | James F. Scarpelli Cumberland, Md. | | | |

MEMORANDUM

TO: SAC, NEW YORK
 FROM: SAC, BOSTON
 SUBJECT: [REDACTED]
 RE: [REDACTED]

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| COUNTY OF [REDACTED] CITY OF [REDACTED] | | COUNTY OF [REDACTED] CITY OF [REDACTED] | |
| DECEASED [REDACTED] | | DECEASED [REDACTED] | |
| SEX: [REDACTED] RACE: [REDACTED] | | SEX: [REDACTED] RACE: [REDACTED] | |
| DATE OF BIRTH: [REDACTED] PLACE OF BIRTH: [REDACTED] | | DATE OF BIRTH: [REDACTED] PLACE OF BIRTH: [REDACTED] | |
| DATE OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED] | | DATE OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED] | |
| CAUSE OF DEATH: [REDACTED] | | CAUSE OF DEATH: [REDACTED] | |
| SIGNATURE OF DECEASED: [REDACTED] | | SIGNATURE OF DECEASED: [REDACTED] | |
| SIGNATURE OF WITNESS: [REDACTED] | | SIGNATURE OF WITNESS: [REDACTED] | |
| SIGNATURE OF PHYSICIAN: [REDACTED] | | SIGNATURE OF PHYSICIAN: [REDACTED] | |
| SIGNATURE OF CLERK: [REDACTED] | | SIGNATURE OF CLERK: [REDACTED] | |

RECEIVED

NOV 9 1955

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10376

0361 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|-------------------------|---|-------------------------|---|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ALLEGANY</u> | | MARYLAND | | STATE <u>MARYLAND</u> | | COUNTY <u>ALLEGANY</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| OR TOWN <u>02 CUMBERLAND</u> | | <u>2 days</u> | | TOWN <u>CUMBERLAND</u> | | <u>02</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | <u>1</u> | |
| <u>62 SACRED HEART HOSPITAL</u> | | | | <u>23 Laing Ave.</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Bessie Veva Whitacre</u> | | | | <u>11-21-55</u> 19 <u>55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>F</u> | <u>W</u> | <u>Widowed</u> | <u>June 7, 1895</u> | <u>60</u> yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housewife</u> | | <u>Own home</u> | | <u>W.V. Elkins</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Joseph Louke</u> | | | | <u>Eleanor Weese</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>None</u> | | <u>Chart</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| <u>443X</u> IMMEDIATE CAUSE (A) <u>Congestive Heart Failure & Anasarca</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Essential Hypertension</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | | |
| <u>0</u> | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | <u>M.</u> | | | | | |
| 22. I hereby certify that I attended the deceased from <u>11/19</u> , 19 <u>55</u> , to <u>11/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/20</u> , 19 <u>55</u> , and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| <u>James F. Scarpelli</u> | | | | <u>11/21/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>11-23-55</u> | | <u>Mt. Savage Meth Cem.</u> | | <u>Mt. Savage, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>November 23, 1955</u> | | <u>Walter R. Frank, M.D.</u> | | <u>James F. Scarpelli</u> | | <u>Cumberland, Md.</u> | |

REPORT OF DEATH

This report is to be filled out by the physician or other person who has attended the deceased, or by the coroner, or by the undertaker, or by the person who has taken charge of the funeral. It should be filled out as soon as possible after death, and before the body is buried or cremated. It should be filled out in the presence of the deceased's family, or other persons who are present at the death, and it should be signed by the person who has filled it out. It should be filed in the office of the health department, or other office designated by the local health officer.

1032 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1032

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX
4. AGE
5. DATE OF BIRTH
6. PLACE OF BIRTH
7. OCCUPATION
8. MARITAL STATUS
9. EDUCATION
10. RELIGION
11. RACE
12. COLOR
13. HEIGHT
14. WEIGHT
15. BUILD
16. COMPLEXION
17. HAIR
18. EYES
19. NOSE
20. MOUTH
21. TEETH
22. SKIN
23. FINGERS
24. TOES
25. FEET
26. HANDS
27. WRISTS
28. ELBOWS
29. SHOULDERS
30. NECK
31. THROAT
32. CHEST
33. BACK
34. LIMBS
35. OTHER

36. CAUSE OF DEATH
37. MANNER OF DEATH
38. TIME OF DEATH
39. PLACE OF DEATH
40. DATE OF DEATH
41. SIGNATURE OF REPORTER
42. SIGNATURE OF WITNESSES
43. SIGNATURE OF DECEASED'S FAMILY
44. SIGNATURE OF CORONER
45. SIGNATURE OF UNDERTAKER
46. SIGNATURE OF FUNERAL HOME
47. SIGNATURE OF BURIAL PLACE
48. SIGNATURE OF CREMATORIUM
49. SIGNATURE OF OTHER

50. SIGNATURE OF HEALTH OFFICER
51. SIGNATURE OF CLERK
52. SIGNATURE OF OTHER

53. SIGNATURE OF OTHER

54. SIGNATURE OF OTHER

55. SIGNATURE OF OTHER

56. SIGNATURE OF OTHER

57. SIGNATURE OF OTHER

BUREAU V. S.

NOV 28 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10377

10369 CERTIFICATE OF DEATH

Reg. Dist. No. 9

| | | | | | | | |
|--|------------------|---|-----------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Allegany | | MARYLAND | | STATE MD. | | COUNTY Allegany | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN 22 Frostburg | | | | TOWN Lonaconing | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 61 Miners Hospital | | | | STREET ADDRESS (If rural give location) Beechwood Street | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| MAY HATTIE WHITEMAN | | | | Nov, 6th. 19 55 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Female | White | Married | April, 18.1900 | 55 yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Lonaconing, MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Dilfer | | | | 14. MOTHER'S MAIDEN NAME Hattie Miller | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT & ADDRESS Simeon Whiteman, Lonaconing, MD | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION (Husband) | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) 602X Pyelonephritis & Abscess formation | | | | | | 10 days | |
| ANTECEDENT CAUSE(S) DUE TO (B) Nephrolithiasis | | | | | | 22- | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Cholecystitis & Cholelithiasis | | | | | | 6 yrs. | |
| 19a. DATE OF OPERATION 1/10/55 | | 19b. MAJOR FINDINGS OF OPERATION 2000 cc Pus - evacuated from abscess | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 10/2 , 19 55 , to 10/6 , 19 55 ; that I last saw the deceased alive on 10/6 , 19 55 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Martha E. Eichel | | DATE THEREOF Nov, 9th. 1955 | | NAME OF CEMETERY OR CREMATORY Memorial Park | | LOCATION (City, town, or county) (State) Frostburg, Md. | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 24. REC'D BY REGISTRAR Ms. Nancy A. Roe | | 25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD. | | DATE 11-10-55 | |

1999

BUREAU A.S.

5561-01-004

RECEIVED

10370

10378

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 9

| | | | | | |
|---|-------------------|--|---|--|--|
| 1. PLACE OF DEATH: | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | |
| COUNTY <u>Allegany</u> | | MARYLAND | STATE <u>Id</u> | | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town) OR | | |
| TOWN <u>Frostburg</u> | | <u>3 hrs</u> | TOWN <u>R.F.D.#1 Frostburg</u> X | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u> | | STREET ADDRESS (If rural, give location) <u>(Klondike)</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | 4. DATE OF DEATH (Month) (Day) (Year) | | |
| (Type or Print) <u>Donald Mac Dougal Winters</u> | | | <u>Nov. 1 1955</u> | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | | 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. |
| <u>Male</u> | <u>white</u> | <u>Married</u> | <u>Nov. 27-1921</u> | | <u>33</u> yrs. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): | | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? |
| <u>Celanese Corp.</u> | | <u>Carlos, Md.</u> | <u>U.S.A.</u> | | |
| 13. FATHER'S NAME: | | | 14. MOTHER'S MAIDEN NAME: | | |
| <u>Arch Winters</u> | | | <u>Sally Haines</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY No.: | 17. INFORMANT & ADDRESS: | | |
| <u>Yes</u> | | <u>W.W. 2 214-16-2872</u> | <u>Miners Hospital records.</u> | | |

| | | | | |
|--|---|---|--------------------------------------|--|
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | <u>3 hrs.</u> |
| <u>981X</u> Immediate cause (a) <u>Shock due to a 12 guage shotgun wound</u> DUE TO Antecedent cause(s) (b) <u>in lower abdomen, perforation of bowel</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>ruptured bladder and right ureter.</u> | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Shot by another man.</u> | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| <u>Nov. 1-1955</u> | | <u>same as cause of death.</u> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>yard</u> | 21c. (City or town) (County) (State) | | |
| <u>Klondike Allegany Md.</u> | | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Nov. 1-1955 P.M.</u> | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>Argument and shot by James Allen, a neighbor.</u> | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | |
| SIGNATURE | | | | |
| <u>H.V. Deming M.D.</u> | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| <u>Burial</u> | | <u>11-5-1955</u> | <u>Frostburg Memorial Park</u> | <u>Frostburg Md.</u> |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS | |
| <u>11-4-55</u> | | <u>Mr. Harvey A. Roe</u> | <u>P.H. Mettling, Frostburg, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 21 1955

RECEIVED

10362 CERTIFICATE OF DEATH

10379

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

| | | | | | | | |
|--|---------------------------|--|---------------------------------------|--|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ALLEGANY</u> | | MARYLAND | | STATE <u>MARYLAND</u> | | COUNTY <u>ALLEGANY</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR | |
| TOWN <u>CUMBERLAND</u> | | <u>4 days</u> | | TOWN <u>CUMBERLAND</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u> | | | | STREET ADDRESS (If rural give location) <u>313 AVTRETT</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>JOHN W YAKSETICH</u> | | | | <u>11-25-55</u> <u>19</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>June 22, 1912</u> | 9. AGE last birthday <u>43</u> yrs. | IF UNDER 1 Year | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Moulder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Foundry</u> | | 11. BIRTHPLACE (State or foreign country) <u>Davis, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Joseph Yaksetich</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Jennie Petovich</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>214-05-5270</u> | | 17. INFORMANT & ADDRESS <u>Old Chart Sacred Heart Hospital</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 581.0 IMMEDIATE CAUSE (A) <u>Hepatic carcinoma & ascites</u> | | | | | | <u>25 days</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>11-22-55</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Paracentesis, 1 gallon fluid</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>10-31-55</u> , 19 <u>55</u> , to <u>11-25-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-25-55</u> , 19 <u>55</u> , and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, state) <u>Cumberland Md</u> DATE SIGNED <u>11-26-55</u> M.D. <u>[Signature]</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>11-28-1955</u> | | NAME OF CEMETERY OR CREMATORY <u>S.S. Peter & Paul Cem.</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| 24. REC'D BY REGISTRAR <u>DATE 28, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> | | ADDRESS <u>Cumberland, Md.</u> | |

CERTIFICATE OF DEATH

DATE OF DEATH

DECEASED'S NAME (Print Name)

PLACE OF DEATH

CAUSE OF DEATH

DECEASED'S ADDRESS (Print Name)

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

INSTRUCTIONS

BUREAU V. 3

NOV 28 1955

RECEIVED

10363 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|----------------------------------|--|-------------------------------------|---|------------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Allegany | | STATE Maryland | | COUNTY Allegany | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland | | LENGTH OF STAY (in this place) 2/24/55 | | CITY (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary | | STREET ADDRESS (If rural give location) 811 Elmwood Lane | | | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) Ellen Zimmerman | | | | 4. DATE OF DEATH (Month) (Day) (Year) November 1, 1955 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow | 8. DATE OF BIRTH 1/1/1868 | 9. AGE last birthday 87 yrs. | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Cardiff, Wales | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Griffith | | 14. MOTHER'S MAIDEN NAME (Unknown) | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT & ADDRESS Allegany County Infirmary Records | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 4222 IMMEDIATE CAUSE (A) | | | | Pulmonary Hypostasis | | 72 hrs | |
| ANTECEDENT CAUSE(S) DUE TO | | | | Chronic Myocarditis | | ? | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | General Arteriosclerosis | | ? | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | Secondary Pneumonia. | | ? | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Feb 24, 1955 , to Nov 31, 1955 , that I last saw the deceased alive on Oct 31, 1955 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE James E. McLean | | | | ADDRESS (Street, city, town, state) 49 Greene St. | | DATE SIGNED 11-1-55. | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | DATE THEREOF Nov. 3, 1955 | | NAME OF CEMETERY OR CREMATORY Greenmount Cem. | | LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 24. REC'D BY REGISTRAR Nov 3, 1955 | | REGISTRAR'S SIGNATURE Walter R. Frank, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer | | ADDRESS Cumberland, Md. | |

INSTRUCTIONS

1 Within corporate limits

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

